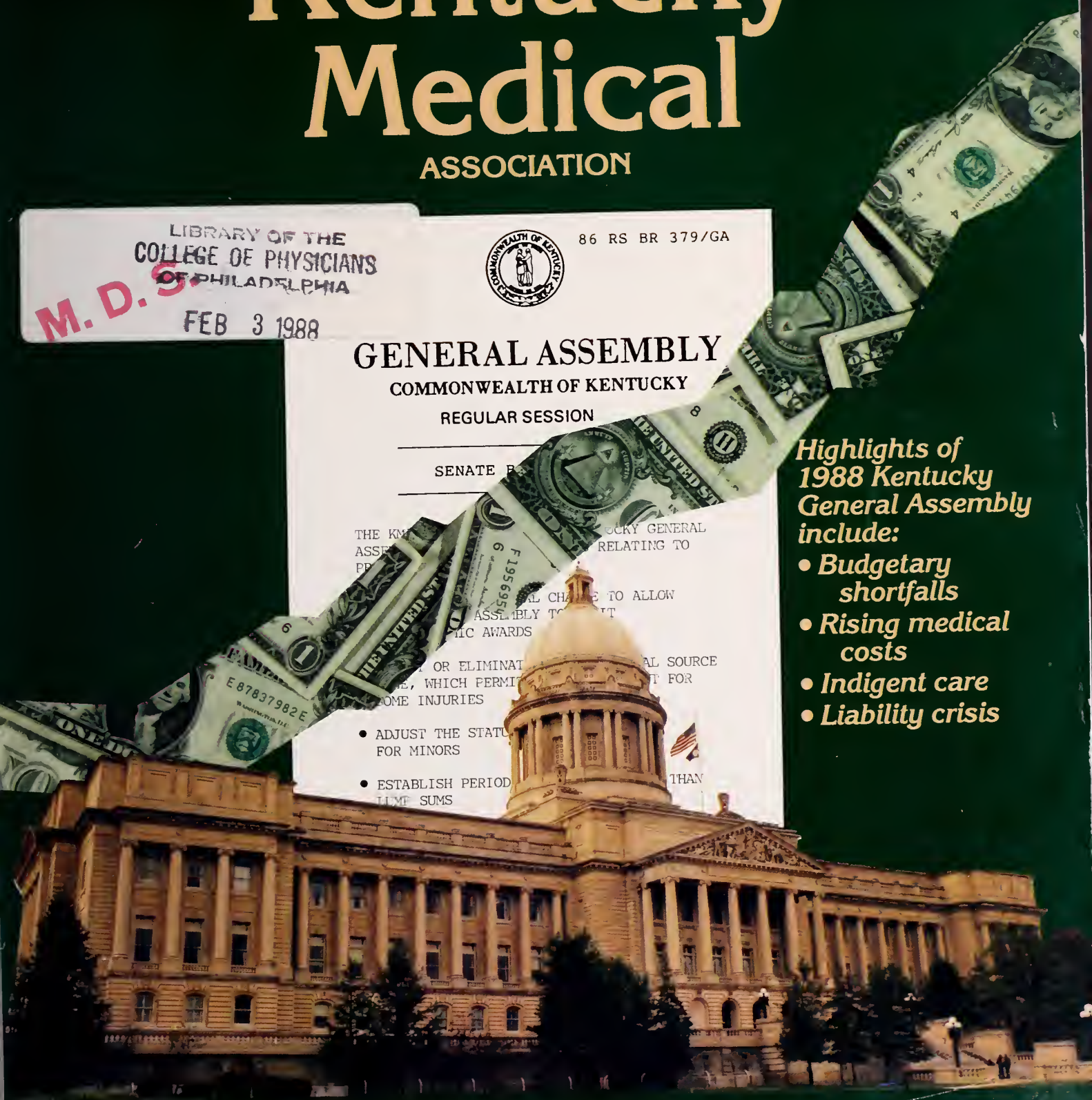
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Volume 86, Number 1 January 1988

SCIENTIFIC

Scanning Pacemaker for Ventricular Tachycardia
Prasad R. Palakurthy, MD; Christopher J. Havelda, MD
Nancy C. Flowers, MD 9

Myoblastoma of the Bronchus
Miguel Ossorio, MD; Thomas M. Roy, MD; Jenny Lynch, MD 13

Angiotensin Converting Enzyme Inhibition in the Management of Congestive Heart Failure (Grand Rounds)
Rick R. McClure, MD 17

EDITORIAL

O.K. You Big Lug, Now Who's Going to Pay for All This Mess? 23

ASSOCIATION

1962-1987 KEMPAC 25th Anniversary 41

REGULAR FEATURES

President's Page 5
Book Reviews 39
CME 48
Classified 48
Clinical Notes on Aging 29
Letters 24

The Cover: Design by Linda Fortwengler

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JANUARY BUYERS' GUIDE FOR JOURNAL OF KMA

Charleston Area Medical Center 35
Classified 48
Elcomp Systems 40
Focus: Healthcare 49
E. F. Hutton 2
Kentucky Air National Guard 44
KMA Insurance Agency 22,38
KMIC 47
KMIC Investment Trust 26
Lexington Clinic 50
Eli Lilly 36,37
Marion Laboratories 26,27
Medical Protective Company 7
M.E.H. Affiliates, Inc. 25
Palisades Pharmaceuticals 49
Roche Laboratories 51,52
Paul Semonin Company Realtors 49
Shepherd Spinal Center 20,21
Smith, Kline and French Laboratories 45
U.S. Air Force 50
U.S. Army 8
The Upjohn Company 28



"Winter in Frankfort, Kentucky — Every Other Year"

As you read this in the warmth of your home or office there is much activity in our capitol city of the Commonwealth. The new Governor, Lieutenant Governor, and cabinet are in place as well as nine new senators out of 38 and 25 new representatives out of 100. This means one out of four individuals now controlling state government are new to the scene.

Kentucky Medical Association is not new to Frankfort. We have our experienced personnel there with Don Chasteen, Bill Doll, and now John Cooper, who have been actively involved in state government many years. They will be involved in the issue of tort reform especially as related to professional liability. Every week your Quick Action Committee consisting of the President, President-Elect, Chairman of the Board, Secretary-Treasurer, Immediate Past-President as ex-officio, and Chairman of the Committee on State Legislative Activities will be meeting and trying to reinforce in every way our liability reform package. This Quick Action Committee will be supported by regular meetings in Frankfort of the Committee on State Legislative Activities as well as the Ad Hoc Committee on Professional Liability. The Auxiliary will have an important function in their phone campaign. You can be sure we will all be busy until the closing gavel on 15 April. We do expect to get something accomplished.

Kentucky is the only state that has not passed any type of legislation to address the problem of excess liability insurance rates. KMA does have a significant plan which we believe will help very much, and we have important allies in all walks of life who are supporting us in this attempt. Our package is generic in that it would bring relief to many other groups in similar situations. Additionally, the Tort Reform Association of Kentucky (TRAK), the Constitution Revision Task Force, the Task Force on Professional Liability Insurance, and the Presidential Task Force on Liability have all gone on record recommending almost all of our platform of reform.

Now, let me get more personal with you and ask you a few questions:

1. Do you know the specific concerns addressed in KMA's effort on professional liability insurance? (See the December issue of the Journal)
2. How important is this in relieving your premium expenses?
3. Who is your state senator? Where does he/she stand on the issue of tort reform and what was his/her voting record during the 1986 session?
4. Ditto for your state representative.
5. Did you give support—both money and/or other activity to your representatives in Frankfort in

their last campaign? How much?

6. If you were in their shoes would you be very favorably impressed by the political activities of the physicians in their community?
7. What other legislative issues may arise during this session of the KGA related to medicine? (Remember during the last session over 150 bills related to medical issues and had to be followed closely.)
8. Will you become adequately involved so that you may help?

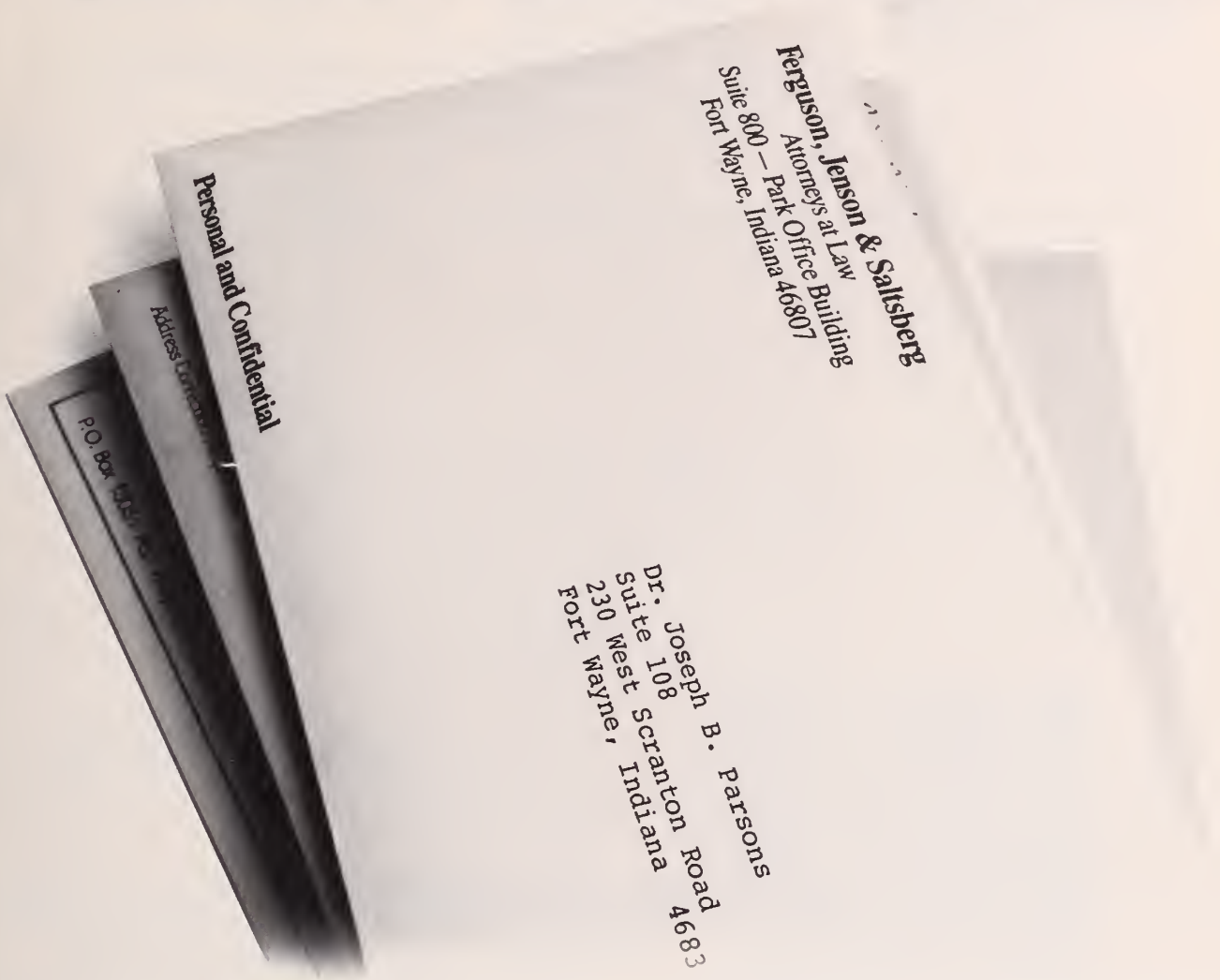
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Wally O. Montgomery, MD
Chairman, State Legislative Committee

NOTE: Please refer to the Legislative Handbook which is enclosed with this issue of the **Journal.**

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Scanning Pacemaker for Ventricular Tachycardia

Prasad R. Palakurthy, MD; Christopher J. Havelda, MD; Nancy C. Flowers, MD

Various permanent pacing modes have been used in the long-term management of ventricular tachycardia. An automatic scanning extrastimulus pacemaker was implanted into a patient with recurrent ventricular tachycardia, refractory to multiple antiarrhythmic agents. This extrastimulus pacemaker has been documented in reversion of multiple episodes of ventricular tachycardia during preimplant electrophysiological testing. The pacemaker terminated exercise-induced tachycardia successfully in the patient described. During the follow-up period of 19 months, the patient had multiple transient dizzy spells. Multiple 24-hour ambulatory monitor recordings did not demonstrate tachycardia. However, telephonic transmission of his electrocardiogram revealed reversion of tachycardia by the pacemaker coinciding with notation of the patient's dizziness. In all documented spontaneous episodes, ventricular tachycardia was terminated with the first attempt.

From Division of Cardiology, Department of Medicine, University of Louisville, Louisville, KY. Reprint requests to 1072 Fourth St, Des Moines, IA 50314 (Dr Palakurthy).

Most available evidence suggests that sustained ventricular tachycardias are due to a reentrant mechanism.[1,2] The distinguishing trait of reentrant ventricular tachycardia is its induction and termination by a critically timed single or double premature stimulus.[1–4] This knowledge has led to the development of a scanning extrastimulus pacemaker that scans the ventricular tachycardia and delivers one or more premature stimuli at a preset programmed coupling interval from the last sensed complex. This is repeated with a decreased coupling interval if ventricular tachycardia persists. Initially, such a pacemaker was used to terminate supraventricular tachycardia.[5] Similar pacemakers have been used for ventricular tachycardia as reported in the literature.[6,7] However, one of these reports failed to demonstrate the function of the pacemaker during follow-up periods.[7] In the other report, the follow-up period was short.[6] Here, we describe a patient with recurrent, refractory ventricular tachycardia in whom the automatic scanning extrastimulus pacemaker was implanted. This pacemaker functioned not only during the electrophysiological study, but also during an exercise study and subsequent follow-up periods.

Description of Automatic Scanning Pacemaker

The Telectronics model 4172 antitachycardia pacemaker is activated automatically and can be programmed to deliver one or two pulses. When programmed for two pulses, confirmation of tachycardia results in the delivery of the first stimulus after the initial delay, followed by the second stimulus, separated by the programmed coupling delay. If tachycardia continues, the scan counter decrements the initial premature delays at 6 ms intervals, yet maintains the programmed coupling delay of the second stimulus. This process will

be repeated up to 15 times yielding a maximum reduction of 90 ms from the original programmed delay. During continuous tachycardia, this sequence repeats, and the cycle resets after the 15th decrement. This pacemaker also has the backup VVI pacing at a rate of 60 bpm.

The pulse generator has a memory feature which retains the timing interval that is successful in reversion of a tachycardia after detection of a subsequent tachycardia. The extrastimulus is delivered at the value held in the memory. Should the retained value be unsuccessful, scanning will continue until the minimum value is reached, then will reset to the programmed initial delay to repeat the cycle.

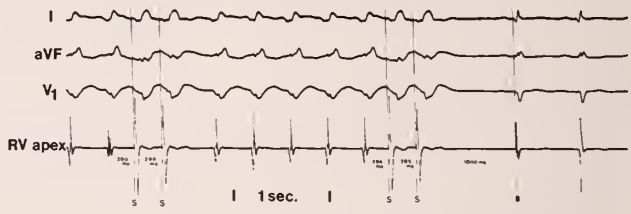


Fig 1. Termination of the ventricular tachycardia by the automatic extrastimulus pacemaker generator. Surface ECG leads I, aVF and V_1 and electrogram from right ventricular apex. The pacemaker generator scanned the tachycardia and terminated it with the second attempt.

Case Report

A 67-year-old male sustained myocardial infarctions in 1960 and 1965. His third myocardial infarction occurred in 1974 complicated by congestive heart failure. Post infarction recovery was complicated by angina and he underwent cardiac catheterization in June 1982. Subsequently, three-vessel coronary artery bypass surgery was performed. Since February 1984, the patient has had multiple admissions to the local hospital for ventricular tachycardia. He was treated with procainamide, quinidine, disopyramide, tocainide and amiodarone at different admissions. The patient continued to experience recurrent tachycardia despite these antiarrhythmic drugs and was transferred to University Medical Center for further investigations.

Physical examination was unremarkable except for a S_4 on cardiac auscultation. The electrocardiogram revealed sinus rhythm with evidence of an old anteroseptal infarction and persisting ST elevation in V_1-V_3 suggesting ventricular aneurysm.

An electrophysiologic study was performed. Baseline recordings revealed AH and HV intervals of 80 ms and 60 ms, respectively. Sinus nodal function was normal. Ventricular tachycardia was induced repeatedly by a single premature stimulus having a cycle length of 400 ms and morphology similar to that of clinical tachycardia. Tachycardia was consistently terminated with burst pacing, but not with the external scanning pacemaker generator using coupled premature stimuli. However, after intravenous administration of procainamide the tachycardia cycle length was prolonged to 500 ms and the external scanning pacemaker was able to terminate the tachycardia consistently.

The tachycardia termination window was determined by scanning diastole with a single right ventricular apical extrastimulus which failed to terminate the tachycardia. However, two premature stimuli with an initial delay of 345 ms and a coupled delay of 285 ms were successful (Fig 1). Left ventricular angiography revealed akinetic septum and anterior wall with no distinct ventricular aneurysm. Therefore, we felt this patient was not an ideal candidate for the antitachycardia surgery.

After extensive discussion, the permanent automatic scanning extrastimulus pacemaker (Teletronics model 4172 PASAR) was implanted. It was programmed to deliver two premature stimuli with an initial delay of 345 ms and a coupled delay of 285 ms. The patient recovered uneventfully. The maximal heart rate was determined by an exercise test. During the testing, the patient developed spontaneous ventricular tachycardia at a rate of 135 bpm. The scanning pacemaker sensed the tachycardia, and terminated it with the first attempt (Fig 2).

Follow-up

The patient was followed for 19 months after pacemaker implantation. During this period he had occasional dizzy spells. Repeat 24-hour ambulatory monitoring revealed multiformed ventricular premature beats and appropriate discharging of the pacemaker at a backup VVI of 60 bpm. In view of the sporadic episodes of dizziness, a transtelephonic follow up (Survival Heart System, New Jersey) was arranged. After an episode of dizziness in September 1985, this telephone system was used to record his electrocardiogram which revealed a run of ventricular tachycardia. The

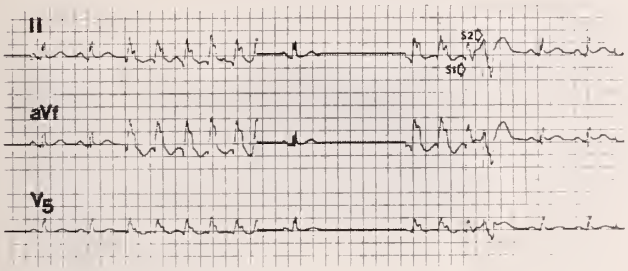


Fig 2. Electrocardiogram recorded during the exercise testing. Patient developed tachycardia (VT) in Stage II of modified Bruce Protocol. Computerized program interrupted the continuous recording to print an average QRS complex and the second half was written from the memory. First two beats of VT did not fulfill the criteria of minimal tachycardia detection rate (130 bpm). Pacemaker sensed and terminated the tachycardia using two extrastimuli (S_1 and S_2). Initial and coupled delays were 345 and 285 ms, respectively.

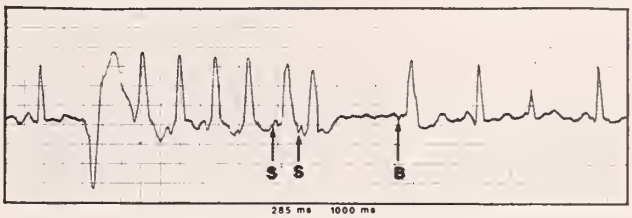


Fig 3. Electrocardiogram (lead 1) recorded at the time of telephonic transmission: A PVC initiated tachycardia. After 4 beats of ventricular tachycardia, pacemaker delivered two premature stimuli and terminated the tachycardia. Pacemaker delivered again at 1000 ms interval (VVI pacing). Pacemaker spikes are not clearly seen in this lead. B = VVI pacing; SS = Pair of premature stimuli.

pacemaker discharged two premature stimuli at a preset coupling delay which terminated the tachycardia (Fig 3). Pacemaker spikes were not seen in Lead 1. However, morphology and intervals were similar to pacemaker initiated beats.

Subsequently, the patient's pacemaker function was reevaluated. Ventricular tachycardia could not be induced by programming a tachycardia detection rate to 65 bpm. Programmed electrical stimulation after placement of an electrode pacing catheter in the right ventricle resulted in the ventricular tachycardia. The pacemaker recognized the tachycardia and terminated it each time. The patient was discharged on the same medications and remains free of significant symptoms except for occasional dizzy spells.

Discussion

Various types of permanent pacemaker modes for the long-term management of ventricular tachycardia have been reported.[6–10] There are three general types of antiarrhythmic pacemakers: (1) underdrive; (2) burst; (and 3) scanning pacemakers. These pacemakers have serious limitations because they can potentially accelerate ventricular tachycardia and induce ventricular fibrillation. Fisher et al[11] reported a 4% incidence of acceleration of ventricular tachycardia and a 1% incidence of pacing induced ventricular fibrillation during attempted termination of 573 episodes of ventricular tachycardia in 23 patients. However, tachycardia acceleration occurred at least once in 43% of the 23 patients. Mason and Winkle[4] reported similar results where tachycardia acceleration occurred at least once in 44% of patients. Of the three modes of pacing, the programmed ventricular extrastimulus pacing appears to pose the least risk of accelerating ventricular tachycardia and/or inducing ventricular fibrillation. Wellens et al[1] and Josephson et al[2] have successfully terminated ventricular tachycardia using one or two premature stimuli without causing subsequent acceleration. However, Spielman et al[12] reported ventricular fibrillation in 8% of their patients with two premature stimuli.

Although this mode of pacing is less risky, implantation of such pacemakers is still infrequent. Reddy et al[16] reported the use of the Teletronics automatic scanning pacemaker in a patient with recurrent ventricular tachycardia. However, concomitant therapy with amiodarone was necessary to provide effective control of the patient's ventricular tachycardia. He was followed for six months and ambulatory monitoring revealed at least 16 episodes of tachycardia. The pacemaker functioned as expected in this patient and successfully terminated all episodes of tachycardia within an average of eight seconds of onset.

Higgins et al[7] implanted the automatic scanning

pacemaker in a 34-year-old male who had recurrent syncope. During his 16-month follow-up, the patient underwent multiple 24-hour ambulatory monitor recordings which failed to demonstrate any episodes of tachycardia.

In conclusion, this pacemaker offers the advantage of conversion before hemodynamic compromise occurs and, thus, may be useful in selected patients. Patient candidates for implantation of the automatic scanning extrastimulus pacemaker must first undergo extensive electrophysiological tests to avoid pacing-induced acceleration of tachycardia and ventricular fibrillation. In patients with recurrent ventricular tachycardia who do not respond or are intolerant to antiarrhythmic medications, the antitachycardia pacemaker may be an option, either alone or in combination with pharmacologic therapy.

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Myoblastoma of the Bronchus

Miguel Ossorio, MD; Thomas M. Roy, MD; Jenny Lynch, MD

Since the first description of the glandular cell myoblastoma by Abrikosoff in 1926,[1] pathologists have debated the etiology of this uncommon tumor. After 60 years of inquiry and intellectual curiosity, it now appears that most pathologists favor the Schwann cell as the parent cell. Most reports of glandular cell myoblastoma involve the tongue, the skin, or the soft tissues. While there has been noted a predilection for occurrence in the head and neck region, this tumor has only rarely been reported in the respiratory tree. The first description of glandular cell myoblastoma of the bronchus was in 1939 by Kramer.[2] Our discovery of a patient with bronchial glandular cell myoblastoma has prompted a literature review and allowed us to update the current information regarding the diagnosis, treatment, and prognosis of the rarest of all respiratory tumors.

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Case Report

G. T. is a 58-year-old black female who was evaluated in March 1984 for a coin lesion in the right midlung. A cigarette smoker, she had noticed a change in her usual daily cough to one that was more frequent. She had also noted that her sputum color had changed from white to a yellow-tan. She denied hemoptysis, fever, chills, chest pain, hoarseness, sore throat, and dysphagia. She denied any constitutional changes such as weight loss, myalgias, or arthralgias.

Her past history was notable for surgical resection of an adenocarcinoma from the sigmoid colon in 1980. All nodes were negative at surgery and follow-up CEA titers were normal. Other surgeries included repair of a ventral hernia in 1981 and a hysterectomy in 1950 for recurrent uterine prolapse.

Pulmonary function studies from 1980 confirmed a moderate obstructive ventilatory defect with the $FEV_{1.0}$ 55% of predicted. She smoked 1½ to 2 packs of cigarettes for a pack year history of 70 years. She recalled having an uncomplicated pneumonia in 1974.

Social history was unremarkable for tobacco and ethanol use on a chronic basis. Family history was unremarkable, with special attention to respiratory illnesses and neoplastic processes. This patient had no identifiable occupational or recreational exposure to chemicals or particulate matters that would affect the pulmonary system.

The complete physical examination documented vital signs that were normal, well-healed surgical scars on the abdomen, and scattered wheezes on both inspiration and expiration that were ameliorated by coughing. The examination was otherwise normal in all respects.

Chest radiograph demonstrated a nodular density at the level of the seventh rib. CT scan of the chest was performed and confirmed that the lesion was solitary

and did not contain calcium.

Other studies that were normal included an electrocardiogram, complete blood count with differential, electrolyte series, urinalysis, and automated chemistries. Room air arterial blood gases revealed mild hypoxemia with normal ventilation and acid-base status. The A-a gradient was 33mmHg.

Spirometry again documented a moderate obstructive process with a measured $FEV_{1.0}$ of 1.45 liters, which was 55% of her predicted. There was no significant response to bronchodilators.

Flexible fiberoptic bronchoscopy was performed and a polypoid mass was identified in the right bronchus intermedius at the level of the superior basilar subsegment. Transbronchial biopsies of the lesion were interpreted as "myoblastoma: granular cell tumor." Due to the patient's limited pulmonary reserve, the lesion was approached again by bronchoscopy by the surgical service. Material removed from the bronchus intermedius was again interpreted as granular cell tumor. Close inspection of the remainder of the tracheobronchial tree was essentially unremarkable and we felt that the lesion found in the right lower lobe bronchus was solitary.

Discussion

Since the initial description of the myoblastoma in 1926, approximately 500 cases have been recorded in the literature. Although this tumor appears to have a ubiquitous anatomic distribution in skin and soft tissue, greater than 50% are located in the head and neck region.[3] The tongue and upper airways are favored sites. Appearance of the tumor in the lower respiratory tract is decidedly less common, with only 10% of the granular cell tumors originating in the tracheobronchial tree.[4] Since the first description of a myoblastoma of the bronchus by Kramer, approximately 45 cases have been collected and reviewed.

The rarity of glandular cell tumors of the bronchus has made it difficult to chronicle the natural course and behavior of this tumor. It has been observed that when the tumor occurs in the tracheobronchial tree, it usually is singular with a sessile appearance. Occurrence at multiple endobronchial sites has an incidence of 7%, with five reported cases. There appears to be a 16% coincidence of associated granular cell tumors occurring elsewhere, usually in the skin or tongue.[5]

The patient with a granular cell tumor of the bronchus usually comes to the attention of the physician because of symptoms of lower respiratory tract dysfunction. The most common symptom is cough, followed by hemoptysis, wheezing, chest pain, pneumonia, and dyspnea. Very few of the recorded cases have been totally asymptomatic[4] and these were discovered during the workup for the radiographic presentation of a solitary pulmonary nodule, as was our patient. Radiographic presentation as a coin lesion has occurred in three cases but most commonly the chest film shows atelectasis and post-obstructive pneumonitis.[4]

Myoblastomas of the tracheobronchial tree have been reported in patients ages 8 years to 59 years old. The median age for presentation is 38 years of age.[6] The tumor has been observed to occur in the right hemithorax twice as often as in the left hemithorax. While some investigators feel that granular cell tumors in general have a predilection for blacks and females, there does not appear to be any racial, ethnic, or sexual distinctions when only myoblastomas of the respiratory tree are considered.[7]

As mentioned earlier, patients with granular cell tumors of the respiratory tree most often have symptoms which reflect partial or complete airway obstruction. With the increasing use of fiberoptic bronchoscopy in the investigation of these symptoms, it is likely that more myoblastomas will be discovered. Endoscopically, the lesions are plaque-like, sessile, or papillary. They vary in size from a few millimeters to 6.5 cm. While the lesion arises in all areas of the bronchi, the mainstem bronchi at or near the carina is the most common location. Rarely, the tumor will occur as a single lesion in the trachea.[8]

The cytology and histology is distinctive if the pathologist has a high index of suspicion. The gross lesion is moderately firm with a yellow to tan appearance on cut section. The tumor cells can be found infiltrating the surrounding normal tissue, and in this fashion entraps and compresses the normal structures. Microscopically the granular cells form nests and sheets and demonstrate abundant, granular eosinophilic cytoplasm. The nuclei are single, round, and described as bland. The cytoplasm contains granules that are PAS positive before and after diastase digestion.[9] Most pathologists feel that few entities are likely to be confused with granular cell tumors if attention is given to the cytoplasmic granules. The hallmark of the myoblastoma is the PAS staining of these cytoplasmic granules.[10]

Although it is a tumor that has specific histiologic characteristics, the rarity of the tumor and its uncommon occurrence in the tracheobronchial tree may pose a problem of differentiation from a clinically suspected malignant process. A high index of suspicion must be

maintained by the pathologist since the granular cell tumor is often associated with pseudoepitheliomatous hyperplasia or squamous metaplasia in the surrounding or overlying epithelium, mimicking carcinoma.[11] Biopsy of the tumor is obviously the best and most definitive diagnostic procedure, but the diagnosis has also been confirmed from bronchioalveolar washings as well as exfoliative cytology.[12]

When addressing the histologic appearance of the tumor, it is of importance to acknowledge that there has been debate regarding the cell of origin of the myoblastoma since its initial description. Obvious from its descriptive name, the myoblastoma was initially felt to arise from striated muscle cells. As technology improved, histiocytes, fibroblasts, undifferentiated mesenchymal cells and Schwann cells have been proposed as cells of origin. With the advent of electron microscopy and improved histologic staining, the parent cell appears to be the Schwann cell, leading to a new appellation—"schwannoma."[13,14,15]

The biologic behavior of the myoblastoma is generally benign with symptoms occurring secondary to local extension and compression. There have been rare reports of extrapulmonary granular cell myoblastomas metastasizing[16] but there is no evidence that myoblastomas of the trachea or bronchi have malignant potential.[17] On pathologic specimens, the tumor is found to extend through the bronchial wall and involve the peribronchial soft tissue in about one-third of the cases.[5,18]

There are case reports of myoblastoma of the lung occurring coincidentally with sarcoidosis[19] with small cell bronchogenic neoplasma,[20] twice with squamous carcinoma[21,22] and twice with adenocarcinoma.[23,24]

Interestingly, the tumor may have some secretory properties. Myoblastoma has been associated on one occasion with hypercalcemia, in which case the authors felt that the tumor was responsible for hypercalcemia via secretion of an unrecognized substance other than ectopic PTH.[24] Elevated titers of carcinoembryonic antigen was thought to be a regular occurrence with myoblastoma,[25] but this has not been a consistent feature.[26]

The basic recommendation for treatment of the myoblastoma, regardless of its anatomic location, has been excision with wide margins.[27] This would seem appropriate for the extrapulmonary tumors in view of the five reported cases of metastasis. Treatment of this tumor when it occurs within the tracheobronchial tree, however, has not been consistent. Some investigators point to the benign nature of the granular cell tumor and use bronchoscopic removal by resection or by carbon dioxide laser treatment.[28] For smaller lesions and multicentric lesions, this approach has been used effectively and successfully. When combined with long-term follow-up, patients seem to do well with a low recurrence rate of less then 10%.[7]

Advocates of more aggressive surgical excision point to the fact that one-third of granular cell tumors have already extended into the peribronchial tissue at the time of diagnosis and offer examples of patients who have developed rather sudden airways obstruction from myoblastomas recurring after inadequate resection by bronchoscopic methods. They also point out that clinical follow-up without revisualization of the airways may be misleading since the tumor must compromise almost 75% of the bronchus or trachea to produce symptoms.[29]

The most rational approach to this usually benign, solitary tumor appears to be offered by Daniel et al.[30] In this study, the authors were able to correlate recurrence with the lesion's size. They found that bronchoscopic removal of myoblastomas in the size range from 3 to 8 mm in diameter was successful without recurrence during long term follow-up. On the other hand, myoblastomas with diameter greater than 8 mm usually had full-thickness wall invasion and so a high likelihood of recurrence when followed endoscopically. Full surgical resection then is advised for granular cell myoblastoma associated with distal tissue destruction from compression or obstruction and for tumors with diameters greater than 8 mm. Bronchoscopic resection appears satisfactory for the smaller lesions and for larger lesions in patients who are not surgical candidates.

The extent laser resection by bronchoscopy will play is still unclear due to the small number of cases reported, but remains an attractive option given the comparative mortality of bronchoscopy versus surgery.

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Angiotensin Converting Enzyme Inhibition in the Management of Congestive Heart Failure

Rick R. McClure, MD

Congestive heart failure (CHF) is a commonly frustrating disorder to manage which carriers a poor prognosis. The following is a brief review of the pathophysiology of CHF and how angiotensin converting enzyme inhibitors (enalapril and captopril) can be used to manage CHF and what effect they have on survival.

Congestive heart failure (CHF) has long been one of the more difficult and frustrating ailments to be faced by nearly every physician in clinical practice. It is estimated that as many as 10 million Americans suffer from congestive heart failure and this number is likely to double by the year 2010. CHF accounts for nearly 500,000 hospital admissions and 4.8 million hospital days annually. One can easily imagine the enormous cost that is generated in providing care for this disorder.

The natural history of CHF is also grim. The Framingham data[2] indicated a first year mortality rate of 20% and 14% for men and women respectively. At five years, the mortality rate was 61% for men and 43% for women. For patients with more severe forms of CHF (New York Heart Association Functional Class III or IV), the mortality can be as high as 34% the first year, 59% the second year, and 76% at three years. In terms of these figures, one can state that CHF carries one of the poorest prognoses of any disease encountered in clinical practice.

Despite the considerable technological advances we have witnessed in the practice of medicine, until recently, there had been no demonstrable improvement in these grave mortality statistics. There has yet to be any well documented evidence that digitalis and/or diuretic therapy, the previous standard of therapy, have had any beneficial effect in terms of survival.[3] But now, the use of angiotensin converting enzyme (ACE) inhibitors, such as enalapril and captopril, has been shown to improve hemodynamics, functional class, and survival in patients with congestive heart failure.[1-8]

Adapted from Medical Grand Rounds given April 15, 1987, University of Kentucky, Albert B. Chandler Medical Center.
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Pathophysiology of CHF

The most common causes of CHF are listed in Table 1.[8] In any of these clinical settings, during the evolution of CHF, the heart exhibits three compensatory mechanisms: hypertrophy, increased inotropy/chronotropy and dilation. Dilation due to increased venous return provides increased ventricular preload and can temporarily compensate for decreased ventricular stroke volume by means of the FRANK-STARLING mechanism (Fig 1). But as the myocardium fails, the curve shifts downward and to the left and becomes flattened such that no appreciable increase in cardiac output is obtained by an increase in preload. As multiple intracellular metabolic processes become deranged, myocardial failure progresses and its function becomes less preload dependent and more afterload dependent, showing significant decline in ventricular stroke volume as afterload increases (Fig 2).[1,8,10,11]

As cardiac output declines, several neurohumoral systems, now commonly called the "Neurohumoral Axis,"[8,10,11] are activated in order to maintain adequate blood pressure and perfusion of vital organs. These systems and their mediators listed in Table 2, are now postulated to be involved in a vicious cycle (Fig 3) that leads to the ultimate progressive deterioration of cardiac function. A cardiac lesion results in decreased cardiac output and poor perfusion peripherally. Compensatory mechanisms are reflexly activated causing vasoconstriction and sodium/water retention which leads

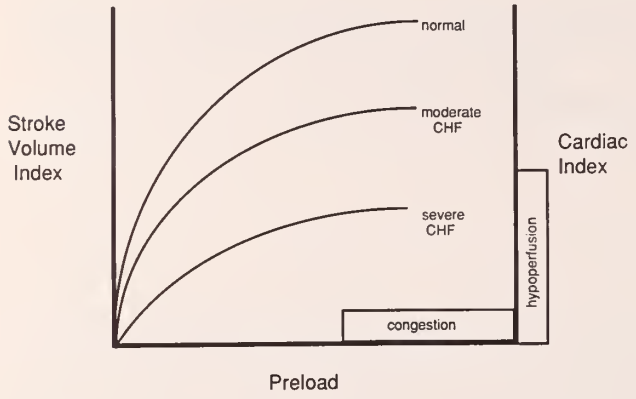


Fig 1. FRANK-STARLING Curves. From Remme WJ. Congestive heart failure–pathophysiology and medical treatment. *Journal of Cardiovascular Pharmacology* 1986: 8 (suppl. 1): 536. Used with permission.

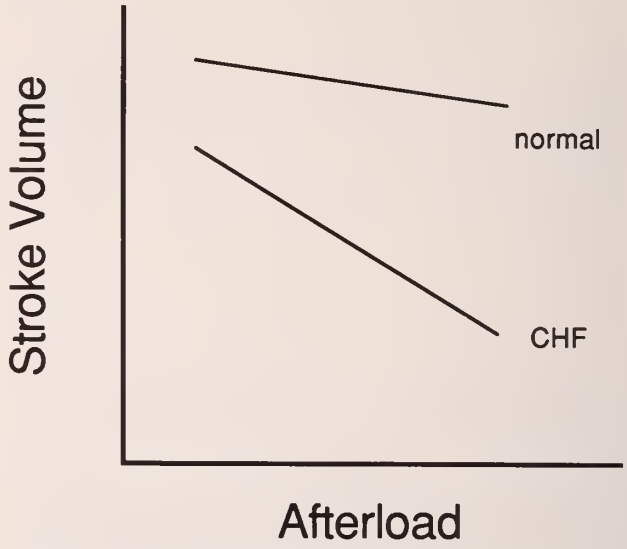


Fig 2. Left Ventricular Function Curve in CHF.

to an increased impedence to forward flow. This increase in impedence or afterload caused further decline in cardiac output in the already failing heart, and the cycle continues.

Eventually, over 90% of patients with CHF die from either progression to more severe CHF or sudden cardiac death in an equal distribution and these systems may play a major role in these events.[13,14]

Effect of ACE Inhibition

It has been clearly documented that the use of ACE inhibitors significantly alters the neurohumoral axis by blocking formation of Angitensin II and breaking the deleterious cycle. This leads to improving hemodynamic parameters by increasing stroke volume and decreasing both peripheral vascular resistance (afterload) and left ventricular filling pressures (preload) over both the short and long term. At the same time, studies have shown a sustained clinical improvement in functional class in patients treated with these agents.[4–6, 15–20]

In June 1987, the CONSENSUS Trial Study Group[9] published data in the *New England Journal of Medicine* showing for the first time an improvement in survival in patients treated with enalapril. This prospective, placebo-controlled trial was terminated early due to ethical considerations after realizing the significant beneficial effect ACE inhibition therapy was having on survival. The trial randomized patients with NYHA Class IV symptoms, who were stable on current doses of digitalis

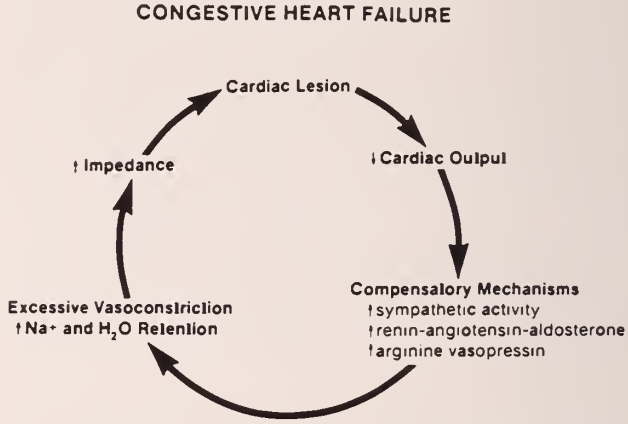


Fig 3. Compensatory cycle in CHF. From Francis GS. Neurohumoral mechanisms in congestive heart failure. *American Journal of Cardiology* 1985; 55: 15A.

and diuretics, to receive either enalapril (2.5 to 40 mg per day) or placebo—127 patients in the enalapril group and 126 patients in the placebo group. The study lasted twenty months and showed a mortality rate of 39% in the enalapril group and 54% in the placebo group—a reduction of 27% (P = 0.003) (Table 3). The reduction in mortality appeared to be mediated through a halt in the progression of CHF and no significant effect was seen on the occurrence of sudden death.

In summary, we appear to have entered a new era in the management of patients with congestive heart failure. We now have available a class of drugs, ACE inhibitors, which have a very acceptable safety profile[10,21]

and low tolerance rate, that are capable of improving hemodynamic profiles, functional class, and most importantly, survival.

Such therapy should be started in the hospital because of the risk of first dose hypotension, and regular monitoring for drug related side effects such as renal insufficiency, proteinuria, and agranulocytosis should be arranged. In stable patients, hypotension can frequently be avoided by withholding the patients' diuretic for one to two days before initiating ACE inhibition therapy and by starting with very low doses (captopril 6.25 mg or enalapril 2.5 mg) and titrating upward as the patient tolerates. Potassium requirements frequently decrease once ACE inhibitors are started and supplements may no longer be needed. One must also be cautious in using potassium sparing diuretics concomitantly, as hyperkalemia can occur.

Finally, ACE inhibition therapy should be considered in any patient with depressed ejection fraction or stroke volume with the goal being improvement in functional class, prevention of progression of disease, and prolonging survival.

Acknowledgements

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TABLE 1

COMMON CAUSES OF CHF

A.	Coronary Artery Disease
B.	Idiopathic Cardiomyopathy
C.	Hypertension
D.	Valvular Heart Disease
E.	Congenital Heart Disease

TABLE 2

NEUROHUMORAL AXIS: SYSTEMS AND MEDIATORS

A.	Sympathetic Nervous System/Norepinephrine - facilitates vasoconstriction and renin release
B.	Renin - Angiotensin - Aldosterione System - facilitates vasoconstriction, sodium and water retention, noradrenergic transmission and arginine vasopressin release
C.	Arginin Vasopressin System - potentiates effects of norepinephrin and angiotensin II and facilitates vasoconstriction

TABLE 3

CONSENSUS MORTALITY DATA

Treatment Group	6 mos.	12 mos.	20 mos.
Enalapril	26%	36%	39%
Placebo	44%	52%	54%
(p Value)	(0.002)	(0.001)	(0.003)

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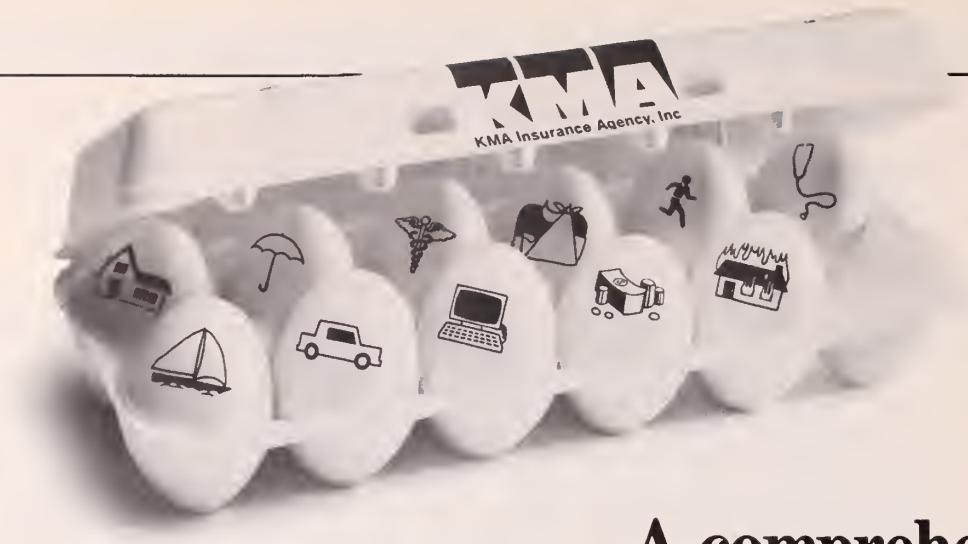
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You have all seen the television commercial. King Kong climbing up the side of the Transamerica Building, creating havoc as he goes. A shapely blonde bombshell in a sequin dress steps out on the parapet to utter those now-famous words.

The mess I now refer to is Acquired Immunodeficiency Syndrome (AIDS) and its long-term or short-term care and management.

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Estimates on the cost of caring for the AIDS patient vary widely. Dollar amounts from 50,000 to 100,000 per case seem to be in the ball park area. Naturally the trend to treat these patients in non-acute beds and settings could reduce this cost.

The *New York Times* last June estimated that in 1991 to care for the anticipated 20,000 cases in New York City would exceed one billion dollars a year. Extrapolate those figures to the entire United States "at risk" population, and we are looking at a dollar figure that promises to make the current health and welfare budget, national defense, and foreign aid look like pocket change.

No need here to review the population at risk from AIDS. Unfortunately it is the type of person at risk that does not seem to engender great sympathy from the general non-risk population. A great majority of the at-risk group is young, bright, and in prime health prior to infection. It is their own volition of life-style and habits that puts them in harm's way.

The great health calamities of the past such as smallpox, tuberculosis, polio and others cut across all segments of society, so great empathy arose from the masses. The financial help and personal donations for Christmas Seals, Easter Seals, the March of Dimes and others all contributed to the medical research that led to the conquest of those dreaded diseases. Can the same hold true for AIDS? Can the fear of AIDS create such public outcry that donations from all sources will pour in to fund research for cure and finally prevention of AIDS?

Cure and prevention of AIDS? Why that is at least five to ten years down the road. How about the here and now in treatment of AIDS? How can that "mess" be paid for?

One way would be a medical insurance policy, much the same that is sold to cover seven dreaded diseases, to include AIDS, and structure the premiums to be actuarially sound. Another way would be to use existing buildings or non-used vacant hospitals to set up sanatoriums specifically for treatment of AIDS. Remember Waverly Hills and Hazelwood for treatment of tuberculosis in the first half of this century? These could be funded by local taxes, federal matching funds, and private donations. A pipe dream you say? Maybe, and maybe not.

For those of us who missed the battle over smallpox, tuberculosis and polio, the coming crisis of AIDS represents "our" war in our lifetime. Let us be equal to the task.

Milton F. Miller, MD

LETTERS

To the Editor:

HEALTH FRAUD HOTLINE
1-800-432-9257

In March of this year the Commonwealth of Kentucky Attorney General, David L. Armstrong, appointed a 15-member HEALTH FRAUD TASK FORCE. The Task Force is responsible for discovering health fraud in Kentucky, educating the public about health fraud, and proposing legislation to control same.

Health fraud in the United States costs its citizens 10 billion dollars annually and the amount in Kentucky is tremendous! Physicians know or hear about health fraud more than any other group; fraud such as nutrition products of questionable value or dangerous contents, nutrition advice by unqualified persons, weight loss schemes, and "miracle" cures for cardio-vascular disease, arthritis, cancer and, more recently, AIDS. These frauds cause people to spend large amounts of money without benefit, delay or deter patients receiving high quality medical care, and endanger health and life itself.

Health frauds will be reported to the proper professional groups and to the Attorney General for legal action when appropriate. If you are aware of or suspect health fraud in any form, report immediately via the HEALTH FRAUD HOTLINE at 1-800-432-9257.

Sincerely yours,
John S. Llewellyn, M.D.

To the Editor:

I greatly enjoyed and endorsed every picturesque and vivid reliving related in your editorial on the 150th anniversary of our Medical School. The editorial was beautifully done, and I appreciated your comprehensive description of the many aspects of our lives on Chestnut Street.

One thing that I have always remembered and would like to add to your editorial was the framed plaque on the wall of the lobby across from the anatomy lab on the fourth floor. As you came out of the hallway into the lounge, it was on the left-hand wall beside the doorway. It said, "Today, I purchased myself the finest spanking bay I could find in these parts, for in view of the human frailty to judge from appearances, it behooves a physician who wishes himself well regarded to make his rounds in a rig befitting his station."

Thanks again for your heartwarming editorial, and you may print my letter for the benefit of the other old M.D.'s that love to remember U. of L. Medical School.

Best regards,
W.F. Clarke, M.D.
Lexington, KY

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68% believe more people bring lawsuits than should.

79% believe a major reason for the rising cost of lawsuits is "people who figure they can make a lot of money from such suits."

64% see "the knowledge that defendants have insurance" as a major reason for the rise in the cost of lawsuits.

Source: Harris Poll 1987

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Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

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References:

1. Korman MG, Shaw RG, Hansky J, et al: *Gastroenterology* 80:1451-1453, 1981.
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J-6138 January 1986

Delirium in The Elderly: Acute Organic Mental Disturbance

Charles Francke, MD, and Steven Lippmann, MD

Delirium is the organic mental disorder most frequently encountered in people over age 65, the most rapidly growing segment of our population. Delirium is estimated to occur in one-third to one-half of elderly persons hospitalized on acute medical or surgical services. This condition is frequently the first herald of physiological compromise in the geriatric patient. Awareness about the signs and symptoms of delirium is essential for a timely diagnosis and appropriate treatment.

Introduction

Delirium, the clinical expression of acute brain failure, is a syndrome of global impairment in cognitive functions due to diffuse derangement of cerebral metabolism.[1] Clinical features include diminished attention, orientation, memory, sleep, and abnormal perception and psychomotor activity. The term delirium is derived from the Latin "de," which means "out of," plus "lira" which means "furrow or track." Thus, being "out of track," delirium implies an abrupt deviation from the individual's usual mental state.[2] Many physical illnesses may present as delirium, especially in elderly people.[3]

Delirium is the organic mental disorder encountered most frequently by physicians,[2] and is the most common psychiatric presentation in patients over the age of 65.[3] Approximately 10% of all persons admitted to acute medical and/or surgical services suffer a delirium. Among the geriatric population, between one-third and one-half of hospitalized individuals become delirious during admission.[1] It is likely that incidence citations would be higher if all patients were subjected to rigorous assessments with repeated mental status examinations.[2] Although delirium may progress to coma and death in 15%–30% of geriatric cases, prompt diagnosis and treatment of the underlying disorder usually results in recovery.[3]

A wide variety of intra- and extra-cranial pathologies can precipitate delirium in older people. As one prominent geriatrician put it, "Acute confusion is a far more common herald of the onset of physical illness in an old person than are, for example, fever, pain or tachycardia."[1] Confusion is one of the most frequent reasons for referral of a patient to a geriatrician. Failure to identify and diagnose delirium or to treat its underlying etiology may have dire consequences, since it may constitute the most prominent presenting feature of pneumonia, myocardial infarct, or other life-threatening illness.[1]

The Clinical Syndrome

Introduction

Variability is the rule in the clinical presentation of delirium. Diagnostic features include vacillating degrees of disability in attention, thinking, sleep, perception, and memory.

Variability

Variability is the most common characteristic of delirium. This includes individual variability as well as fluctuations over time. Sources of variability include the underlying physiological derangement as well as differences in personality. For example, the degree of dehydration often changes at different times in the day; similarly, one delirious patient may become withdrawn and paranoid, while another becomes agitated and assaultive based on premorbid individual characteristics.

From the Department of Psychiatry and Behavioral Sciences, University of Louisville School of Medicine, Louisville. Reprint requests to Humana Hospital University-5 East, 530 South Jackson Street, Louisville, KY 40202 (Dr Lippmann).

Attention

Inability to sustain and focus attention is the principle deficit which, along with sleep/wake disturbance, accounts for a cardinal feature, "clouding of consciousness."[1] Thinking and speech become fragmented. Recent memory deficits result from the inability to register new information. Disorientation to time, place, and/or person results from inability to attend to surroundings.[3]

Thinking

Thinking is disorganized and fragmented. Delirious persons tend to experience uncontrolled and often disturbing dream-like imagery or disjointed thoughts. The elderly delirious patient is more likely to have impoverished and incoherent thought processes. The inability to reason, think abstractly, understand similarities, or define words becomes obvious.[1] At times perseverations appear; the patient may go over a thought or a subject repetitively, unable to distract from it. Behavior may be influenced by a single stimulus, to the neglect of more serious considerations.[2] Such disordered thinking is frequently labeled "confusion" in Nurses' Notes.

Delusions or false beliefs are common in delirium.[2] They differ from schizophrenic delusions by being poorly systematized, more influenced by the environment, transient, and vague. Paranoia, including overt persecutory delusions or unrealistic suspiciousness, occurs in about 50% of the delirious elderly and is the most common delusional presentation.[3]

Sleep/Wake Cycle Disturbance

Disordered sleep and wake cycles are essential features of delirium. Wakefulness may be reduced during the day and abnormally increased at night.[1] Delirium often appears first at night with fragmentation and reduction of sleep. Patients often describe experiencing a "dream-like" feeling in a state between sleep and wakefulness.[3] Both delirium and sleep are associated with electroencephalographic (EEG) slowing of background rhythms. The close association between this syndrome and fragmentation of the normal sleep/wake cycle is an important diagnostic aspect of delirium.[1]

Psychomotor Behavior

Three behavioral forms of delirium are described: hyperactive, hypoactive and mixed.[4] In hyperactive delirium, patients may be agitated and autonomic arousal may be marked, including tachycardia, diaphoresis, dry mouth, dilated pupils, etc.[3] The hypoactive variant is characterized by decreased psychomotor activity and alertness. This presentation is the most likely one to be overlooked or misdiagnosed.[4] Lipowski states that the mixed form is the most common.[3] Typically, hypoactivity may predominate during the day; it is opposite at night.[1]

Memory Impairment

Memory impairment in delirium includes defective registration, retention, and retrieval of information. Recent memory is the primary deficit.[1] Immediate recall is severely impaired, probably because of reduced attention span. Retrograde and antegrade amnesias occur.[3]

Upon recovery, patients are often unable to recall events in the course of their deliria. Memories are fragmented and unclear. Hallucinations, however, are sometimes recalled.[5]

Disorientation

Orientation refers to correct knowledge of time, place, and person.[3] Orientation to time is the most easily impaired function; thus, it is the most sensitive diagnostic measure.[6] The delirious patient may confuse days, dates, and even years.[5] Disorientation to self rarely occurs, but the delirious patient may fail to recognize others,[6] eg, they may mistake hospital staff for relatives.

Perceptual Abnormalities

Perceptual abnormalities include distortions, illusion, or hallucinations. Distortions refer to changes in the quality, form, or intensity of real sensory experience, and may involve alteration in the size of objects (eg, micropsia) or in the shape, position, or apparent movement of stationary objects. There may be disturbance in body image, depersonalization, or derealization.[3]

Illusions (misinterpretations of sensory stimuli) are common in organic brain diseases, but are rare in functional psychiatric disorders.[5] Illusions may occur in visual, auditory, tactile, and kinesthetic modalities,[3] with visual and tactile illusions the most frequent.[5] Visual or auditory illusions are facilitated respectively by deficits in sight or hearing, typical of many older people. Examples of illusions include mistaking routine noises for a gunshot, seeing folds in the sheet as snakes, or identifying spots on the floor as insects.[3] If the delirium is not severe, the patient may be able to correct the misperceptions, but with more pronounced cases, they

may believe in the veracity of the misperceptions and act accordingly.[2]

Hallucinations are perceptual experiences noted without external sensory stimuli. Hallucinations in delirium are characteristically vivid and most commonly visual or tactile in nature. Auditory hallucinations do occur but are usually associated with functional psychosis. Similar to other perceptual abnormalities, these also may be perceived as "real" by the delirious patient.

Physical Examination

A thorough physical examination is expeditiously performed on all patients with delirium. The examination protocol follows conventional guidelines. Where the history or inspection leads to suspicion of a particular process (eg, pneumonia), that system should receive special attention. Generally, cardiopulmonary-vascular and neurological assessment receive emphasis—with special alertness for signs of organ failures. Any manifestation of autonomic nervous system (ANS) dysfunction may occur in delirium. In varying combinations we may observe any of the following: pallor, flushing, sweating, anhidrosis, miosis, mydriasis, tachycardia, bradycardia, palpitations, hypotension, hypertension, fever, hypothermia, nausea, vomiting, diarrhea, constipation, and incontinence.[7] A careful assessment of autonomic signs in the delirious patient may help lead to the correct etiological diagnosis. For example, diaphoresis occurs in an alcohol withdrawal state, mydriasis in atropine poisoning, or miosis in an opiate overdose.

TABLE 1

SUGGGESTED LABORATORY WORK-UP FOR DELIRIUM

Initial Studies
CBC with differential and sedimentation rate
Serum chemistries profile
Urinalysis
Toxicologic
Chest x-ray
EKG and EEG
Some Other Considerations
CAT scan
Lumbar puncture - CSF examination
Blood levels of medications, ABG, Mg
Thyroid function tests
F.T.A.
Others, as indicated

The neurological examination may reveal abnormalities with a diverse range of signs such as fasiculations, hyperreflexia, ataxia, tremors, seizures, or other abnormalities depending on the disease process. Asterixis and multifocal myoclonus deserve special attention because of their relative specificity for delirium. Although commonly described as a sign of hepatic encephalopathy, asterixis ("liver flap") may occur in delirium of other etiologies. Bilateral asterixis is virtually pathognomonic of delirium.[5] Multifocal myoclonus consists of irregular, asymmetric contractions of muscles or groups of muscles. Muscles of the face and shoulder are most prominently affected, although any area may be involved. Multifocal myoclonus is also essentially pathognomonic of delirium.[2, 5]

Asterixis and multifocal myoclonus are the only two signs of neurological dysfunction that have any degree of specificity for delirium; however, their presence is rare even in overt, classical delirium. All other neurologic signs and symptoms are nonspecific findings.

Laboratory Studies

Whenever the history and physical examination reveal a suspected etiology for the delirious process, laboratory tests are primarily directed at confirmation. In

TABLE 2

COMMON CAUSES OF DELIRIUM IN THE ELDERLY

Medications:	sedative-hypnotics (ingestion or withdrawal, especially of alcohol), analgesics, anticholinergic agents, anticonvulsants, antihypertensive agents, antiparkinsonian agents, cardiac glycosides, cimetidine, disulfiram, insulin, neuroleptics, opiates, phencyclidine, salicylates, steriods, others.
Poisons:	carbon monoxide and heavy metals, etc.
Cardiovascular:	congestive heart failure, myocardial infarction, cardiac arrhythmias, hypotension, hypertension, anoxia.
Metabolic:	dehydration or electrolyte imbalance, hepatic, renal, and pulmonary failure.
Endocrine:	pituitary, thyroid, parathyroid, pancreas, and adrenal hypofunction or hypofunction.
Infections:	pneumonia, urinary tract infection, bacteremia, septicemia, cholecystitis, meningitis.
Neurologic:	transient ischemic attacks, stroke, ictal and post-ictal states, subdural hematoma.
Neoplastic:	primary or metastic brain disease, paraneoplastic syndromes (eg, SIADH).
Trauma:	concussion, hip fractures, burns, operative and post-operative complications.

a simplified example, therefore, a dehydrated, elderly pneumonia patient must receive a chest x-ray, sputum smear, and complete blood count (CBC) as the initial assessment. Blood urea nitrogen (BUN), serum electrolytes, and urinalysis should be obtained as well, depending on the degree of suspicion for dehydration. A more complete laboratory screening evaluation would be obtained depending on the severity of the condition.

In circumstances where no specific diagnosis is obvious, a much more generalized evaluation, including a complete serum chemistry profile, CBC, urinalysis, chest x-ray, electrocardiogram (EKG), and electroencephalogram (EEG), is recommended. Toxicologic studies are a very frequent addition. Then, other pertinent studies would be taken, either for confirming a disease process, such as by obtaining arterial blood gases in a pulmonary embolism case, or more complete evaluations, such as of cerebrospinal fluid, where indicated, etc. (Table 1).

Predisposing Factors

Three factors predispose to delirium: increased age, brain damage, and alcohol or drug abuse. The mechanism of increased vulnerability to delirium with advancing age is unknown, but the association between brain damage and delirium is well documented.[6, 4] Delirium frequently occurs with alcohol or drug intoxication, addiction, and in withdrawal states.[6] Impaired drug metabolism makes the elderly highly susceptible to drug-induced delirium.[1] Substance abusing patients, too, are more subject to vitamin and other nutritional deficiences and other factors (eg, infection or injury) which enhance likelihood of developing a delirium. Greater attention to patients with these vulnerabilities should aid in the early recognition of delirium.

Etiology

A diverse group of substances and ailments can result in delirium. Any medication is suspect when evaluating delirium in the elderly. Table 2 lists some frequently implicated medications. Anticholinergic preparations warrant special emphasis. Over 600 commonly used medicines have anitcholinergic actions capable of producing brain toxicity. These include antihistamines, antispasmodics, antiparkinsonian agents, cycloplegics, mydriatics, antipsychotic drugs, and antidepressants. The signs and symptoms of anitcholinergic blockade are flushed skin, dry mouth, tachycardia, dilated pupils, blurred vision, constipation, urinary retention, and hyperpyrexia.[3]

TABLE 3

DIAGNOSTIC CRITERIA FOR DELIRIUM[7]

A.	Clouding of consciousness (reduced clarity of awareness of the environment, with reduced capacity to shift, focus, and sustain attention).
B.	At least two of the following:
	1. perceptual disturbance: misinterpretations, illusions, or hallucinations
	2. speech incoherence
	3. disturbance of sleep-wakefulness cycle
	4. abnormal psychomotor activity level
C.	Disorientation and memory impairment.
D.	Clinical features that develop acutely (usually hours to days) and tend to fluctuate.
E.	Evidence, from the history, physical examination, or laboratory tests, of a specific organic factor judged to be etiologically related to the disturbance.

Many physical illnesses can cause delirium in the elderly (Table 2). Especially consider cardiovascular, neurologic, metabolic and infectious disease processes. Myocardial infarctions, cardiac arrhythmias and congestive heart failure may cause cerebral hypoxia and result in delirium. Up to 40% of geriatric patients with acute confusional episodes have cardiovascular problems, especially myocardial infarctions without pain.[3] Cerebrovascular accidents, too, may present with delirium, even some without primary motor or sensory deficits. Fluid and electrolyte imbalances are the most prevalent metabolic causes. Infections such as pneumonia, urinary tract infections, or bacteremia initially may be silent among the elderly, yet present in delirium.

Diagnosis

The diagnosis of delirium is based on recognizing the diagnostic criteria (Table 3). History obtained from family, friends, and medical records should include complete drug and medical histories. The mental status examination is the mainstay of the evaluation. It should be thorough, comprehensive, and repeated, serially (Table 4). Meticulous physical and neurological examinations along with appropriate laboratory tests are required to establish the diagnostic etiology. In delirium, the EEG typically will show generalized slowing. In some substance abuse cases, however, fast wave abnormalities may occur. Serial EEGs may be helpful in following the course of the delirium with abnormalities paralleling cognitive change.

TABLE 4

MINI MENTAL STATE

Maximum Score	Score	
		Orientation
5	( )	What is the (year), (season), (date), (day), (month)?
5	( )	Where are we (state), (county), (town), (hospital), (floor)?
		Registration
3	( )	Name 3 objects: 1 second to say each. Then ask the patient all 3 after you have said them. Give 1 point for each correct answer. Then repeat them until he learns all 3. Count trials and record.
		TRIALS
		Attention and Calculation
5	( )	Ask patient to spell "world" backwards or do serial 7s (stopping after 5 answers).
		Recall
3	( )	Ask for 3 objects repeated above. Give 1 point for each correct.
		Language
9	( )	Name a pencil and watch. (2 points) Repeat the following, "No ifs, ands or buts." (1 point) Follow a 3-stage command: "Take a paper in your right hand, fold it in half, and put it on the floor." (3 points) Read and obey the following: "Close your eyes." (1 point) Write a sentence. (1 point) Copy a design, eg, a square (1 point) *Assess* level of consciousness, eg, alert, drowsy, stupor, coma.

Scoring:
Total Possible - 30
Normal - 25-30
Depression likely - 19-25
Dementia - less than 19

TABLE 5

DELIRIUM VS DEMENTIA

Feature	Delirium	Dementia
Onset	Rapid	Insidious
Duration	Brief	Chronic
Consciousness	Fluctuates	Normal
Orientation	Abnormal	May be normal in mild cases
Memory	Impaired	Impaired
Attention	Impaired	Intact in mild cases
Perception	Frequent and vivid misperceptions	Misperception uncommon
Thinking	Content rich and disorganized	Contents empty and stereotyped
Sleep/wake cycle	Disturbed	Variable
EEG	Abnormal	Normal to slowing in late stages
ANS	Commonly abnormal	Usually normal

Differential Diagnosis

Delirium must be differentiated from functional conditions and dementia. The history and mental status examination usually permits accurate differentiation.

In functional conditions (eg, schizophrenia), orientation, attention, and awareness are preserved. There are no fluctuations in the level of consciousness. Affect is typically described as blunted in schizophrenia versus intense and variable in delirium. Hallucinations more commonly are visual in delirium and auditory in functional psychosis. Characteristically, there is no memory loss or other general cognitive impairment in functional disorders.

In hysteria when disorientation occurs, it is frequently to person. This is rare in all but the most severe delirium. Cognitive impairment, when present, is out of proportion to the patient's obvious alertness and responsiveness. Hallucinations are rare in hysteria, but if there, they are usually naive or theatrical.[5]

Delirium and dementia frequently coexist, making diagnosis difficult. Delirium has a more rapid onset, in the range of hours to days. Its course fluctuates throughout a 24-hour period and is frequently worse at night. Alertness may be increased or decreased in delirium, but should be normal in dementia. Hallucinations, rare in dementia, are frequent and vivid in delirium, especially the visual and tactile forms[1] (Table 5). The occurrence of acute autonomic dysfunction would tend to exclude most dementing illnesses.

Significant signs of autonomic or neurologic dysfunctions are uncommon in functional illness. When these are present, delirium is more likely. The appropriate etiology should then be aggressively sought and treatment plans designed according to the specific pathophysiology.

Treatment

Treatment of the underlying cause is essential. Effective management while the medical workup is ongoing involves several aspects; physiologically maintaining oxygenation, hydration, nutrition, and

electrolyte balance is of primary importance. An environment that is quiet, simple, and orderly is best. A lighted room, presence of family members, calendars, and a window are helpful. At night, allow sufficient light to visualize the surroundings, but not enough to disrupt sleep.

Protection of the patient when his behavior is potentially dangerous to himself or others is critical. Physical restraints may be appropriate. Make restraints the least restrictive and for the least amount of time as possible and under constant, close nursing observation.

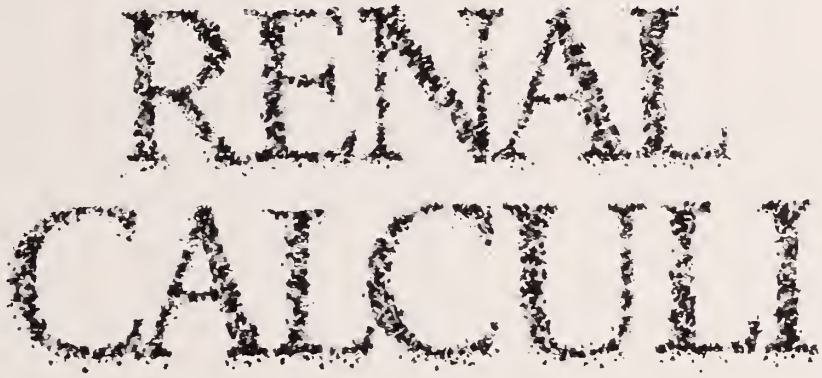
Pharmacological treatment as a restraining measure should be used only when well indicated and stopped as soon as possible. First, pharmacotherapy addresses the etiologic pathology; secondarily, the goals of pharmacologic management are to control behavioral symptoms, potentially dangerous behavior, and correct the sleep/wake cycle disturbance.[3] A benzodiazepine, carefully titrated clinically, such as the short-acting drug lorazepam, 0.5 mg at bedtime, is recommended if insomnia is the predominant symptom. Benzodiazepines are also very useful for behavioral control, by oral or parenteral administrations, and are very often the preferred first means of pharmacotherapy in an agitated delirium case. The primary side effect is sedation. Teratogenicity may exist, as well. Benzodiazepines are otherwise notoriously safe, with the major precaution of their injection intravenously being associated with significant, dangerous respiratory depression, and combated by slow drug administration. The neuroleptic drug heloperidol, too, is a potential drug choice in a very disruptive, agitated psychotic delirium. Its advantages include low sedative and anticholinergic properties and availability in oral or parenteral forms. Muscular stiffness, rigidity, and tremor are the primary side effects. Doses as low as 0.5 mg–5.0 mg po or IM may be adequate. If insomnia is also a problem, nocturnal dosing may suffice.

Conclusions

The incidence of delirium is increasing in parallel with the growing population over age 65. Medical science is now able to sustain life longer and under more adverse conditions. An increasing awareness of delirium in the elderly patient is essential to allow earlier diagnosis and specific, etiologic treatment of the underlying pathological processes, and to diminish dangerous degrees of agitation.

References 1. Lipowski ZJ: Transient Cognitive Disorders (Delirium, Acute Confusional States) in the Elderly. *Amer J Psychiatry*, 140:1426–1436, 1983. 2. Wells CE: Organic Syndromes: Delirium, in *Comprehensive Textbook of Psychiatry IV*, Fourth Edition. Edited by Kaplan, HI and Sadock, BJ. Baltimore, Williams and Wilkins, 1985, pp. 838–851. 3. Beresin EV: Delirium in the Elderly: Assessment and Management, 1986:1–10. 4. Liston EW: Delirium in the aged. *The Psychiatric Clinic North America*. 5:49–66, 1982. 5. Wells CE, Duncan, GW: Delirium, in *Neurology for Psychiatrists*. 6. Devaul RA, Guynn RW: Delirium. Taylor RB, *Difficult Diagnosis*. WB Saunders Co, 1985:84–90. 7. American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*. ed 3. Washington DC, American Psychiatric Association, 1980, pp 101–107. 8. Folstein MF, Folstein SE, McHugh PR: *J Psychiatr Res*, 1974, 12, 189–198.

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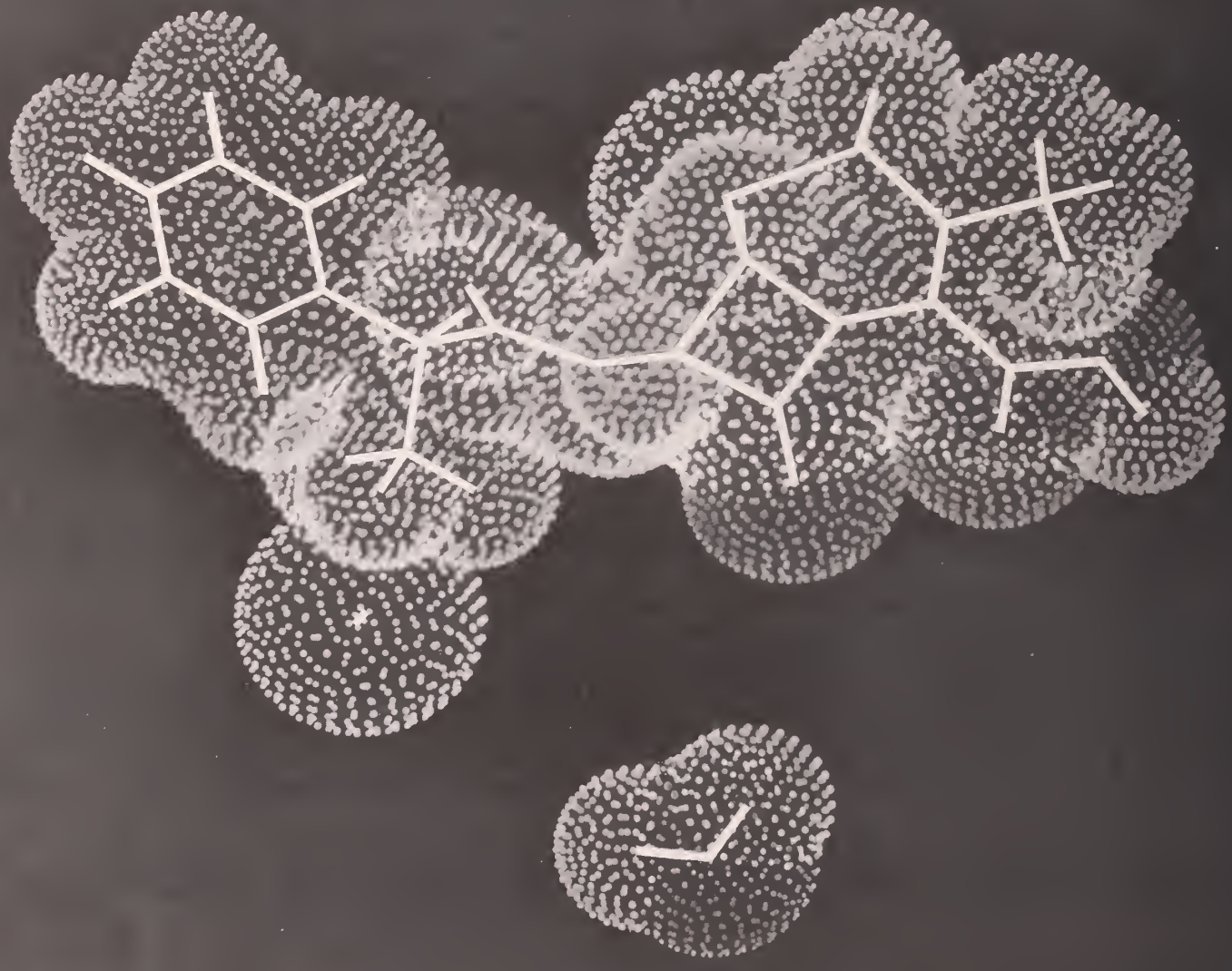
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*Due to susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.
† Due to susceptible strains of *Escherichia coli*, *Proteus mirabilis*, and *Klebsiella* sp.
‡ Due to susceptible strains of group A β-hemolytic streptococci.

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Summary: Consult the package literature for prescribing information.

Indications and Usage:

Respiratory tract infections caused by susceptible strains of *Streptococcus pneumoniae* and group A β-hemolytic streptococci.

Skin and skin structure infections caused by susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.

Bone infections caused by susceptible strains of *S aureus* and/or *Proteus mirabilis*.

Genitourinary tract infections, including acute prostatitis, caused by susceptible strains of *Escherichia coli*, *P mirabilis*, and *Klebsiella* sp.

Contraindication: Known allergy to cephalosporins.

Warnings: KEFTAB SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:

- Discontinue Keftab in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Keftab should be administered cautiously in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy and lactation. Cephalexin is excreted in mother's milk. Exercise caution in prescribing Keftab for these patients.
- Safety and effectiveness in children have not been established.

Adverse Reactions:

- *Gastrointestinal*, including diarrhea and, rarely, nausea and vomiting. Transient hepatitis and cholestatic jaundice have been reported rarely.
- *Hypersensitivity* in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis.
- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruritus, genital moniliasis, vaginitis/vaginal discharge, dizziness, fatigue, headache, eosinophilia, neutropenia, and thrombocytopenia; reversible interstitial nephritis has been reported rarely.
- Cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment.
- *Abnormalities in laboratory test results* included slight elevations in aspartate aminotransferase (AST, SGOT) and alanine aminotransferase (ALT, SGPT). False-positive reactions for glucose in the urine may occur with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

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Sickle-Cell Anemia and Thalassemia (A Primer for Health Care Professionals)

The Canadian Sickle-Cell Society
PO Box 13156, Station A
St. John's, Newfoundland
Canada A1B 4A4
Edited by RG Huntsman, MD

Primers are conceived to be handy, readable, basic mini-texts packed with information at an affordable price for the student and practitioner. Canadian medicine contributes this excellent short book for the consumption of anyone dealing with hematological disease. Paperback, priced at $10.00, and the noncommercial product of the Canadian Sickle-Cell Society, this book will be easily accepted.

Sixty-eight pages at the beginning comprise the first section which is concerned with clinical material. Geographical distribution of abnormal hemoglobins, inheritance of hemoglobins, pathogenesis of sickle hemoglobin, and details of sickle-cell disease are discussed. A comparable explanation of the thallasemias, both major and minor, as well as the smaller group of rarer thallasemias, follows. Eight problems, starting with a presenting scenario, problem, suggested tests, and finally concluding notes, are very educational. Succinct, devoid of pictures and diagrams, without a hint of Canadian language—these pages are the heart of the book for the clinician.

Section II is the basic science division, meant to update the reader in recent advances. For most of us this section will be abstruse. Certainly slow to read and guided by writers who talk to a sophisticated audience, this part can be a reference rather than nighttime reading.

Tables and figures as well as a glossary are appended and are very useful. Full explanations follow each entry, with an eye to the novice in these sections.

Overall a very good primer, this book is a bargain and probably by its purchase we can perpetuate the good work of its editors.

Neurology - Problems in Primary Care

James L. Bernat, MD
Fredrick M. Vincent, MD
Medical Economics Books, Oradell, New Jersey 07649, 1987

Medical Economics Books apparently plans to publish a series of books for the family practitioner, this being the first one. Many patients present their physician with complaints referable to the nervous system, and the authors, both neurologists, describe their approach to diagnosis and management.

In the Assessment section the neurological examination and selection of relevant tests are clarified. Presenting symptoms and the neurologist's assessment are explained in a cookbook style. Subsequently many of the more common and some of the rare neurological diseases are discussed. These subjects are placed in groups belonging to the divisions of the nervous system and are thus readily referenced on quick review. Very little basic science or anatomical material is included—this book is a practical manual, not by any means a textbook. Tables in this section are particularly germane and carefully selected, but the entire book contains scattered tables that are well worth review.

Neurological complications of alcoholism, cancer, pregnancy, diabetes, drug administration, etc, are discussed toward the end, with the background from the preceding chapters used extensively. Finally, a unique Appendix containing names and addresses of service agencies and philanthropies is exciting, having sources for disposition of problems categorized.

Indexes are frequently incomplete, but this one has almost an encyclopedic content with many cross references.

Such a book aimed at the family practitioner is well worth having, especially for those who can use the information in their everyday practice.

Stephen Z. Smith, MD

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KEMPAC 25th Anniversary



Harold L. Bushey, MD, Barbourville, KEMPAC Chairman, welcomes the guests to the 25th Anniversary KEMPAC Seminar.

The American Medical Political Action Committee (AMPAC) was founded in 1961, becoming the first non-union political action committee in the United States. The following year the Kentucky Educational Medical Political Action Committee (KEMPAC) was organized, being one of the first political action committees in Kentucky.

In the 25 years since its inception, KEMPAC has supported an extremely high level of victorious candidates. In order to be a recipient of KEMPAC's support, the candidate must have a proven record of understanding and seeking medicine's position on health care issues. When two candidates have similar qualifications, but one is an incumbent and is a "friend," KEMPAC supports the incumbent. In campaigns where there are two qualified candidates with no past record, KEMPAC supports the candidate with the strongest physician support. KEMPAC supports only one candidate in a particular race.

Interest levels within the medical community have grown tremendously



Sara Gail Travis (L), Lexington, KEMPAC Director, and Carolyn Kurz, Lexington, Executive Director of the Fayette County Medical Society, accepted the Second Place Award for Fayette County in the 100 or more KMA members category.

over the years, and to help educate and stimulate the physicians and their families, KEMPAC/AMPAC have sponsored political education programs.

On September 14th, in Louisville, Kentucky, KEMPAC held its 25th Anniversary celebration. Harold L. Bushey, MD, KEMPAC Chairman, who presided at the meeting, welcomed the guests, including many state legislators. David B. Stevens, MD, Lexington, KEMPAC Membership Chairman, recognized KEMPAC's charter members, past chairmen, and presented membership awards.

Joseph L. Hatch, MD, Salt Lake City, Utah, AMPAC Chairman, spoke on behalf of AMPAC regarding its political activity this past year. He recognized two Kentucky physicians for their outstanding leadership in organized medicine. Hoyt D. Gardner, MD, Louisville, and Fred C. Rainey, MD, Elizabethtown, served on the original KEMPAC Board and have subsequently served as its chairman and also chairman of the AMPAC Board. Both physicians are past presidents of KMA, and Doctor Gardner is a past president of the AMA.

This past year KEMPAC began the practice of presenting membership awards to county medical societies, congressional districts, and individuals who have shown outstanding membership promotion.

You have the opportunity to be a winner next year. Advance the cause of responsible and responsive government by promoting KEMPAC/AMPAC membership, education, and action. Only by working together can we become an effective bipartisan force.



Joseph L. Hatch, MD, Salt Lake City, Utah, AMPAC Chairman, speaks on behalf of AMPAC.





Accepting First Place KEMPAC Membership Awards for the category of 100 or more and 50 to 100 KMA members: Larry Franks, MD, McCracken County (left photo), and Donald C. Barton, MD, Whitley County.

_____ I wish to become a KEMPAC/AMPAC member. Enclosed is my personal check for $100.00

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If your practice is incorporated, KEMPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK. Contributions are not limited to the suggested amount. Neither the AMA nor the KMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions.

A portion of voluntary political contributions will be used in connection with the Federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act.



David B. Stevens, MD, Lexington, KEMPAC Membership Chairman, presents the First Place Award for the highest percentage of KMA members belonging to KEMPAC in a congressional district to Samuel J. King, MD, KEMPAC Director for the Seventh Congressional District.



Recipients of the county 100% KEMPAC Membership Award were Samuel J. King, MD (L), Pike County, and Carl Cooper, Jr, MD, Trimble County.



Paul E. Lett, MD, Ashland, accepts the Second Place Award for Boyd County in the 50 to 100 KMA members category.



Charles F. Allnutt, MD, Lakeside Park, was recognized as the top recruiter for 1987 KEMPAC membership.

After Breast Cancer Woman to Woman II

The Thursday Breast Cancer Support Group, McDowell Cancer Network, and American Cancer Society sponsored a one-day program entitled, "After Breast Cancer Woman to Woman II: A Seminar for Women Who Have Had Breast Cancer." Over a hundred women from Kentucky attended this uplifting seminar held in Lexington on Saturday, November 14, 1987.

The program included sessions on medical issues, nutrition, exercise, image, and appearance. Shelley Hill-Grant, a well-known fashion model who was a breast cancer patient, delivered the keynote address, "The Positive Side." Other highlights of the day included a luncheon, fashion show, and belly dancer. The belly dancer and models, who were breast cancer patients, showed everyone that women could still feel fit and look good after breast cancer.

A new session added this year, "For Men Only," helped husbands and friends of breast cancer patients share their concerns about breast cancer. Congressman Larry Hopkins moderated this session. Other panel members included a physician, pastor, sex counselor, and a spouse of a breast cancer patient.

For more information about "After Breast Cancer Woman to Woman" or any cancer related topic, call 1-800-4-CANCER.

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Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl (brand of cimetidine hydrochloride) injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline (Theo-Dur®, Key Pharmaceuticals, Inc.), demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. (Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.)

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states (e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation), predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients (approximately 1 per 100,000 patients), including agranulocytosis (approximately 3 per million patients), have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia (approximately 3 per million patients) and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 (intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 (intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 (intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. (237 ml.) amber glass bottles and in single-dose units (300 mg./5 ml.), in packages of 10 (intended for institutional use only).

Injection:
Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl (brand of cimetidine hydrochloride) injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

* ADD-Vantage® is a trademark of Abbott Laboratories.

BRS-TG:L738 Date of issuance Apr. 1987

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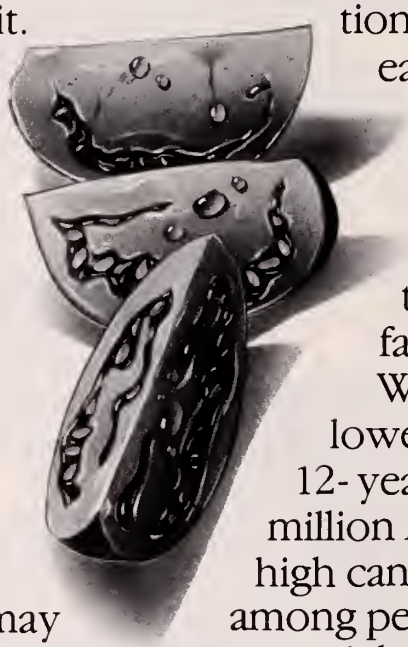
Foods high in fats, salt- or nitrite-cured foods like ham, and



fish and types of sausages smoked by traditional methods should be eaten in moderation.

There is evidence that diet and cancer are related. Some foods may promote cancer, while others may protect you from it.

Foods related to lowering the risk of cancer of the larynx and esophagus all have high amounts of carotene, a form of Vitamin A which is in cantaloupes, peaches, broccoli, spinach, all dark green leafy vegetables, sweet potatoes, carrots, pumpkin, winter squash and tomatoes, citrus fruits and brussels sprouts.



Be moderate in consumption of alcohol also.

A good rule of thumb is cut down on fat and don't be fat.

Weight reduction may lower cancer risk. Our 12-year study of nearly a million Americans uncovered high cancer risks particularly among people 40% or more overweight.



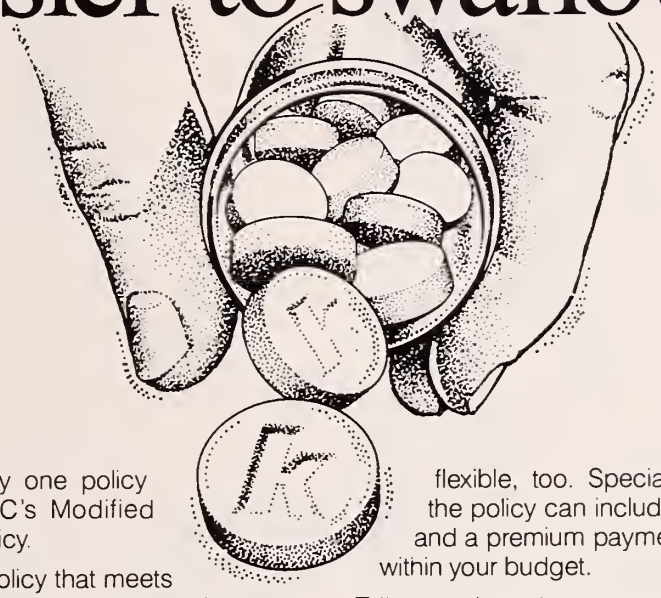
Foods that may help reduce the risk of gastrointestinal and respiratory tract cancer are cabbage, broccoli, brussels sprouts, kohlrabi, cauliflower.

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21-26 Nineteenth Family Medicine Review - Session I, University of Kentucky, Lexington, Kentucky. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

10-13 Sports Medicine - For ALL Practitioners, La Posada Resort, Scottsdale, Arizona. Contact: Stuart C. Zeman, MD, Course Chairman, 2999 Regent St #203, Berkeley, California 94705, (415) 540-8686.

February - April The Johns Hopkins University School of Medicine 29th Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. Home Study Course A is provided each registrant for personal reading and microscopic study at their own laboratory in preparation for Course B. Contact: John K. Frost, MD, 604 Pathology Building, The Johns Hopkins Hospital, Baltimore MD 21205.

APRIL

15-16 First Annual Markey Cancer Center Symposium: Biologic Response Modifiers, Lexington, KY. For physicians and nurses. Contact: Hilary Wood, RN, MSN, (606) 257-4500.

25 - May 6 The Johns Hopkins University School of Medicine 29th Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. In-Residence Course B is an extremely concentrated lecture series with intensive laboratory studies and vital clinical experience at the Johns Hopkins Medical Institutions, Baltimore MD. Contact: John K. Frost, MD, 604 Pathology Building, The Johns Hopkins Hospital, Baltimore, MD 21205.

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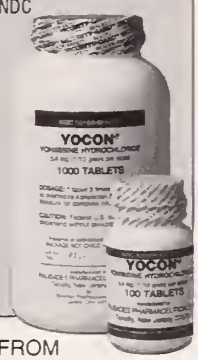
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References:

1. A. Morales et al., New England Journal of Medicine: 1221, November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter. 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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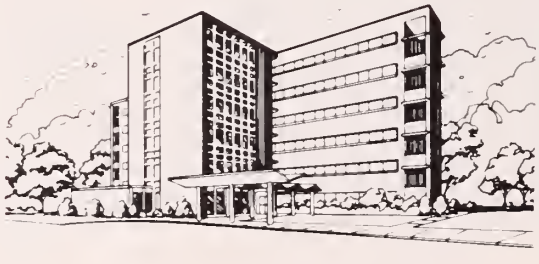
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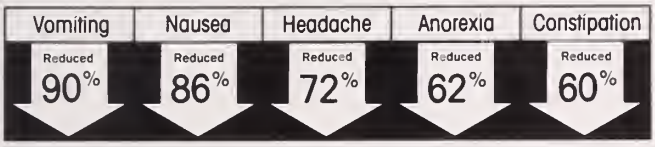
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References: 1. Feighner JP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients. (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

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Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
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Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. I.V. administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single *h.s.* dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
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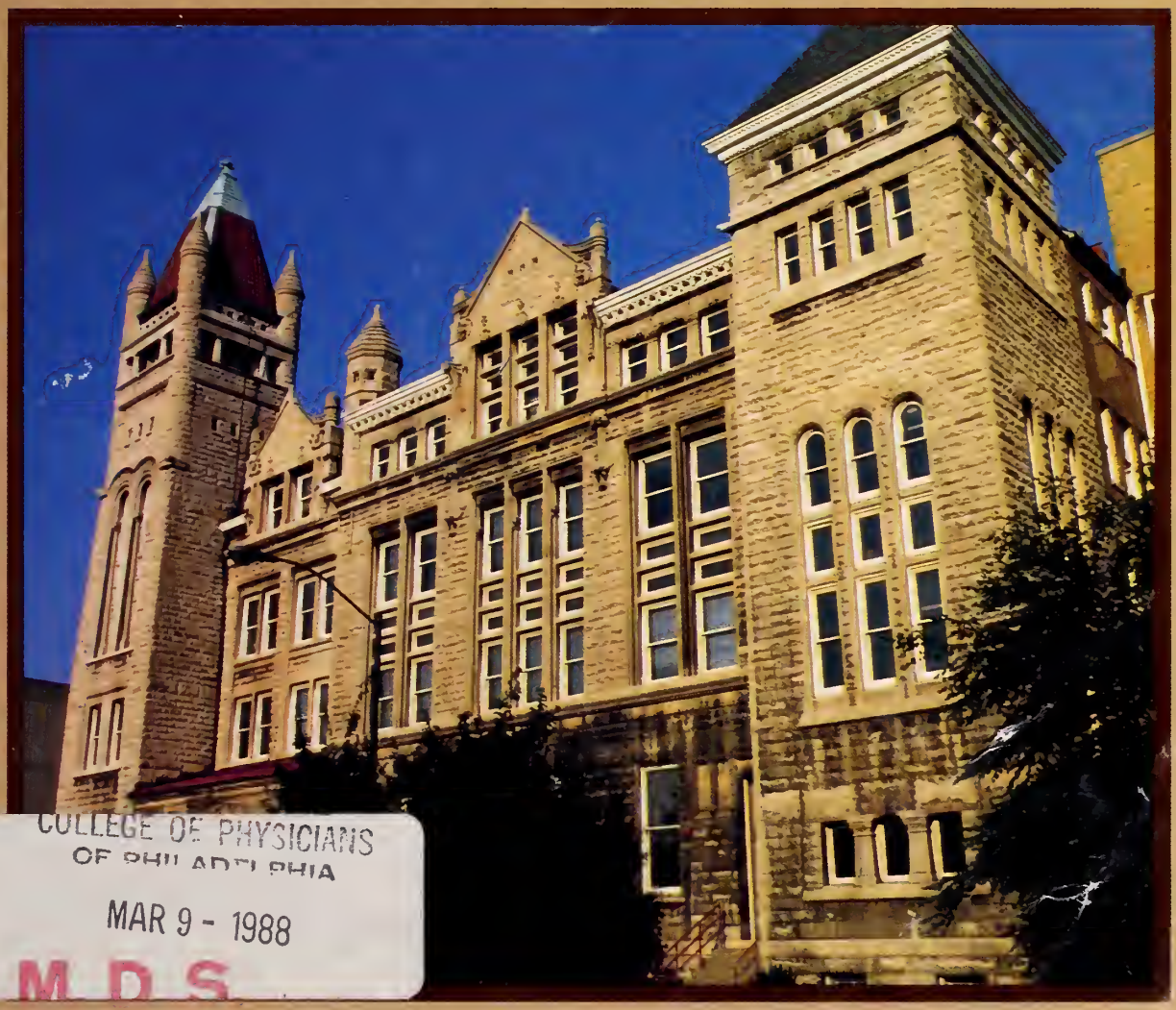
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page 81

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Copperhead Snakebites Reported to the Kentucky Regional Poison Center 1986: Epidemiology and Treatment Suggestions
Bruce David White, DO; George C. Rodgers, Jr, MD, PhD; Nancy J. Matyunas, PharmD; Frank Allen, BA, BS 61

Site-Specific Cancer Mortality Among Kentucky Residents, 1971–1985
Carl W. Spurlock, PhD 67

Breast Reconstruction (Grand Rounds)
Gregory L. Brown, MD 73

SPECIAL ARTICLE

Our Stubbornness Allowed Us to Deliver a Jewel 81

EDITORIAL

Why Me? 79

ASSOCIATION

1987 Actions of the KMA Judicial Council 99
Workshops 101
Updates 102

REGULAR FEATURES

President's Page 57
Auxiliary 93
Book Review 91
CME 92

The Cover: The old U of L Medical School Building has turned into a Jewel (see article page 81).

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Campbell Laboratories, Inc. 80
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Elcomp Systems 60
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KMA Insurance Agency, Inc. 78,96
KMIC 88
KMIC Investment Company 90
Kentucky Air National Guard 98
Key Pharmaceuticals 97,98
Eli Lilly & Company 76,77
Medical Protective Company 59
Roche Laboratories 105,106
Shepherd Spinal Center 94,95
Smith, Kline & French 103
U. S. Air Force 80
The Upjohn Company 104



Crossroads

Greetings and Happy New Year wishes to all of my fellow KMA members. Thank you for the honor you have given me by allowing me to serve as your President-Elect. I look forward to working with you as we attempt to deal with the challenges facing our profession.

We are starting a new year, but the news is not all good. Doctors face the same old problems and unsettled issues from the past. As you read this article, we shall be in the midst of legislative battle to bring some relief to the malpractice crisis. If you have not yet joined this fight, I urge you to become involved NOW.

Over the past decade, we have seen our ability to deliver quality care threatened. Our profession has become fragmented and divided. Doctors have become just another commodity in the marketplace. I think we can all agree that many factors have led to this current situation. The cuts in Medicare directly affect the quality of care our elderly citizens receive. The Health Cost Management Concept promulgated by enterpreneurs, third party carriers, and hospitals (profit and non-profit) has also altered the way we practice medicine.

Unprecendented rises in health care costs over the past two decades have caused frustration for everyone. Unfortunately, doctors are usually blamed for cost increases and too many people still think that doctors benefit from them. In actuality, most of the factors relating to health care costs are out of our control. These soaring costs catapulted our profession into a major industry in which the total health dollar spent equals approximately one-tenth of our nation's gross national product. This brought many non-physician health care deliverers into our system. Under the guise of maintaining health care costs, they ask patients and doctors to accept inconveniences, hardships, and decreases in quality of care. In addition, the health companies ask for a direct discount on our professional fees.

Now, I don't think that doctors object to doing everything possible to cut the cost of health care. My concern is whether we are asking our patients to endure inconveniences and decreased quality of care, along with our personal sacrifices, to actually decrease health care costs, or are we merely allowing the enterpreneurs to maintain their profit levels. Major third party carriers predict that the cost of their policies will escalate from 25% to 50% in the next year. This does not lend credence to the fact that we have effectively contained medical costs. Rather, our patients have lost the freedom to choose the physician and facility of their choice, and our profession has polarized into small segments of MDs with specialized concerns. As a result, doctors have begun to fight fellow doctors in order to gain favor with large corporate structures.

We have successfully cut all the fat out of the system. Any further cuts will result in an untenable situation where our patients will be asked to pay the price and make up the losses hospitals, hospital corporations, and third party carriers have sustained in the past two years. These financial losses are a direct result of hospitals and hospital companies who compete to gain the major share of the market and control the flow of patients to individual institutions and their physicians. I think it is wrong for these same groups to ask doctors to pay a discount in order to take care of sick people — a job for which we have been professionally trained. None of us has any hesitation about

discounting a portion or all of a patient's bill if he is unable to pay. Physicians throughout this state have done this for years and will continue to help people in need. Of course it is preferable if the patient is the direct beneficiary. It does seem ironic that doctors are asked to subsidize both hospitals and hospital companies, both profit and non-profit, and third party carriers so that they can further control the direction of patients and maintain their profit levels.

Both of these situations seem untenable to me and to the physicians I encounter each day. The time has come when we, as professionals, must individually and collectively make a decision about the direction we need to take in order to preserve the quality of medicine which our patients have enjoyed in the past.

Some physicians say it is too late to alter the course — that we should prepare ourselves as deliverers of health care to be one more negotiable item in the marketplace. I do not subscribe to this fatalistic attitude, but I am realistic enough to know that unless we physicians decide how to alter the course of our profession and then pursue it with all our energy, we will not be able to effect any significant improvement in our situation. Physicians must take the lead to regain control of the care of the sick. Let me remind you that not one prescription can be written or one order given by anyone other than a licensed medical person. No institution or corporation can sell one policy which includes professional care unless they have the cooperation and agreement of our fellow physicians.

Rarely a day goes by that I do not hear the questions "What is KMA doing about our problems? What are you going to do to help?" As I mentioned before, organized medicine must be ready to take whatever direction is necessary to solve the problems. However, organized medicine can only be as strong and have as much courage and guts to do what is right as its members have.

We doctors stand at a crossroad. We see what has happened to us in the past, and we see the freedoms that we have lost and the decreased quality of care for our patients. Now is the time for each of us to look into our own soul and conscience and make a decision about the direction we want to take in the future. Once this decision is made by each individual, then this can be parlayed into action by your State Medical Association.

I see three possible options available to physicians. One option is to simply say "NO." Each individual physician can say, "No, we as a profession shall no longer give anyone a discount to be able to practice our trade of healing the sick. We will not participate in any plan which we feel offers inferior facility health care or which burdens our patients with unnecessary and unsafe inconveniences." We also must say NO to any plan which limits our ability to choose the best facility for our patients and restricts a patient's ability to choose his own physician. If this is the majority feeling within our membership, then your KMA should work to change its course in order to carry out your desires. We must become a more activist organization; we must point out to the public and the public media the flaws of the system and the inherent dangers of a cost control management and inform the public that the emphasis of the hospitals and hospital corporations is to maintain their profit and justify maintaining unnecessary beds.

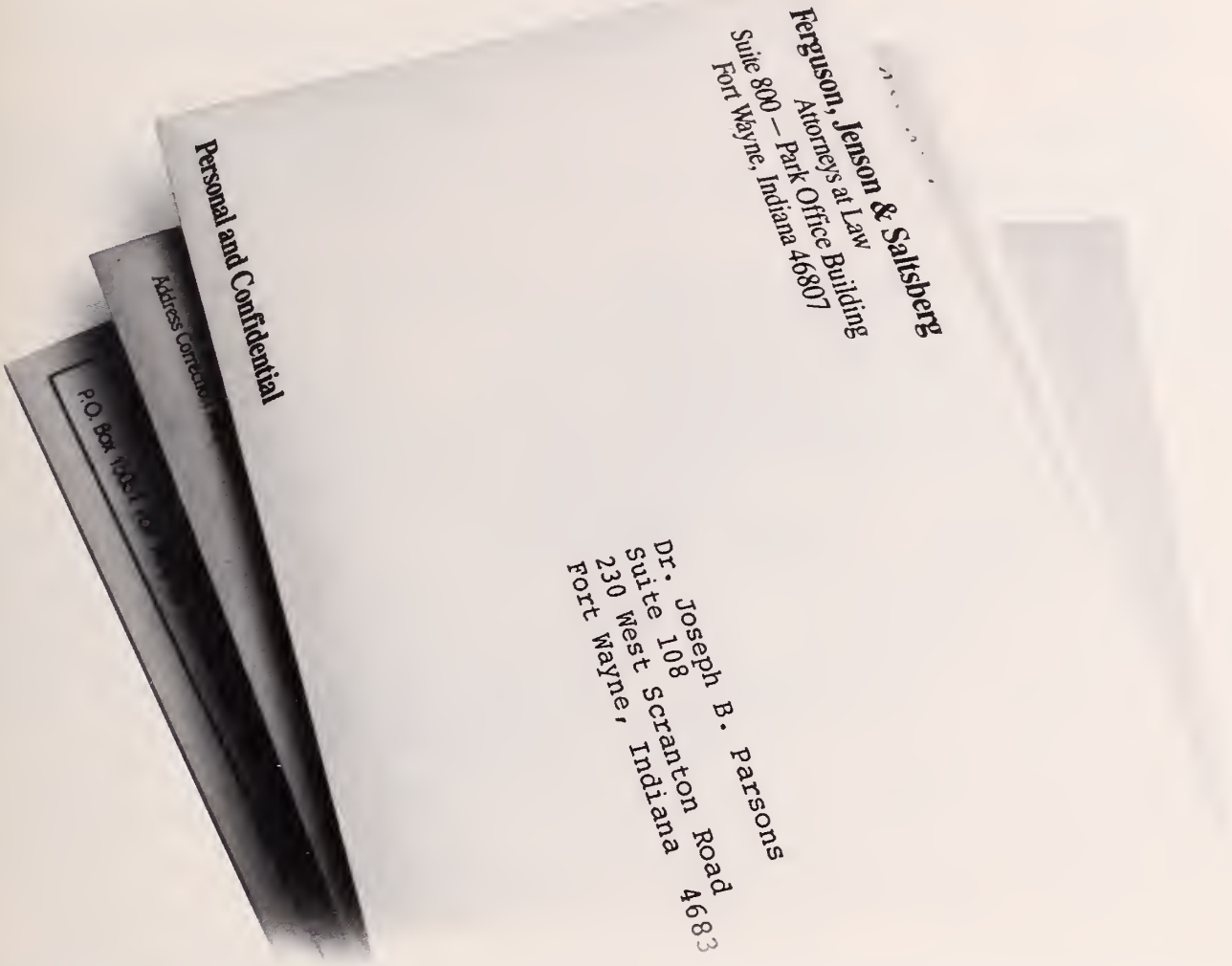
Another option available to all of us is to continue toiling and struggling with the present system and trying to cut the best deal we can. If this is our preference, then organized medicine must gear itself to become a negotiating arm for physicians. We must then set the standards for what is considered to be minimal care, and we must speak out and inform the public of the pros and cons of those plans which do not meet what we consider minimal quality standards. For too long the risk management quality standards have been applied to physicians by non-physicians. It is now time that we physicians establish our risk management program and minimum quality care that we will accept by third party carriers and hospital corporations.

Thirdly, we could always be content to stand by and watch the quality of our health system deteriorate until it is totally unacceptable to the public or to any honest physician. I do not think that any member of KMA would subscribe to this philosophy. It is possible that if we do not act soon, we shall continue to fragment until we will be unable to negotiate except from a point of weakness.

We have moved into the year 1988. Let's not find ourselves writing about these same problems a year from now. Let's work together and present a united front so we can preserve quality health care for our patients, our friends, our neighbors, our families and all members of our society. We are doctors — trained to make decisions and follow through on them. We can't stay at the Crossroads forever. We have to take one road or another, and we have to take it quickly.

Bob M. DeWeese, MD
President-Elect

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Copperhead Snakebites Reported to the Kentucky Regional Poison Center 1986: Epidemiology and Treatment Suggestions

Bruce David White, DO; George C. Rodgers, Jr, MD, PhD
Nancy J. Matyunas, PharmD; Frank Allen, BA, BS

Twenty-six cases of copperhead snakebite reported to the Kentucky Regional Poison Center in 1986 are reviewed. Data collected by the Poison Center is analyzed, emphasizing points important in diagnosis and initial treatment.

Poisonous snakebites are a known hazard.[1,2] About 150 cases are thought to occur in Kentucky each year; less than 0.5% of which are fatal.[3] The number of snakebites reported to the Kentucky Regional Poison Center has been increasing steadily over the past few years. About one-fourth of these cases were known copperhead bites. Confirmed copperhead bites far exceed the number of confirmed rattlesnake and cottonmouth envenomations reported.

The copperhead (*Agkistrodon*) is the most common poisonous snake in Kentucky.[3,4] Three other venomous genra inhabit the state as well, but to a much lesser extent—the rattlesnake (*Crotalus*), pigmy rattlesnake (*Sisturus*), and cottonmouth (*Agkistrodon*). Copperheads, with coppery-rich red hourglass patterns for protective coloration, have been reported throughout the Commonwealth. Rattlesnakes displaying yellowish, greying, or near-black crescents and "rattles," are usually seen in the rocky slopes and crags of eastern Kentucky. The pigmy rattlesnake resembles other rattlesnakes except for its "crown" of scales and is found along the Tennessee state line. The cottonmouth, a uniformly dark snake, is primarily restricted to the backwater areas of the state's Jackson Purchase counties.

From the Kentucky Regional Poison Center of Kosair Children's Hospital and Departments of Pediatrics and Surgery, University of Louisville School of Medicine, Louisville, Kentucky.

The Kentucky Regional Poison Center received 41,076 calls in 1986.[5] Of these, 33,013 (80%) were exposures. Snakebites accounted for less than 0.3% of the poisoning incidents reported. Even though the numbers are small, the potential for morbidity and mortality from poisonous snakebites is substantial. This article will review the copperhead snakebite cases reported to the Commonwealth's Poison Center together with treatment recommendations.

One recognizes immediately that the data from such a retrospective study of reported cases may be skewed because not all envenomations are reported to the Regional Poison Control Center. However, chart review does allow the opportunity to consider the subject within the patient care context and to reassess current management plans of typical cases.

Statistical Review of 1986 Reported Cases

Table 1 gives the number of cases reported over the last three years. Twenty-six cases of copperhead bite were reported to the Kentucky Regional Poison Center during 1986. Fig 1 shows the location, by county, of each call. There appears to be a predilection for eastern Kentucky. Table 2 indicates that most of the cases were reported, as would be expected, in the warm spring and summer months, June through September (23 cases, 88.5%).[2] Table 3 shows that most bites occurred either just before noon (seven cases, 26.9%) or between 4 PM and 10 PM (12 cases, 46.2%), a pattern previously reported by herpetologists.[2]

The victims were noted to be primarily in two age groups: 3 to 5 years (seven cases, 26.9%) and 20–40 years (13 cases, 50%) (Table 4). All but two were male. Table 5 summarizes the case data. The body parts most frequently involved were finger/hand/wrist (16 cases, 61.5%) and foot/ankle (seven cases, 26.9%).

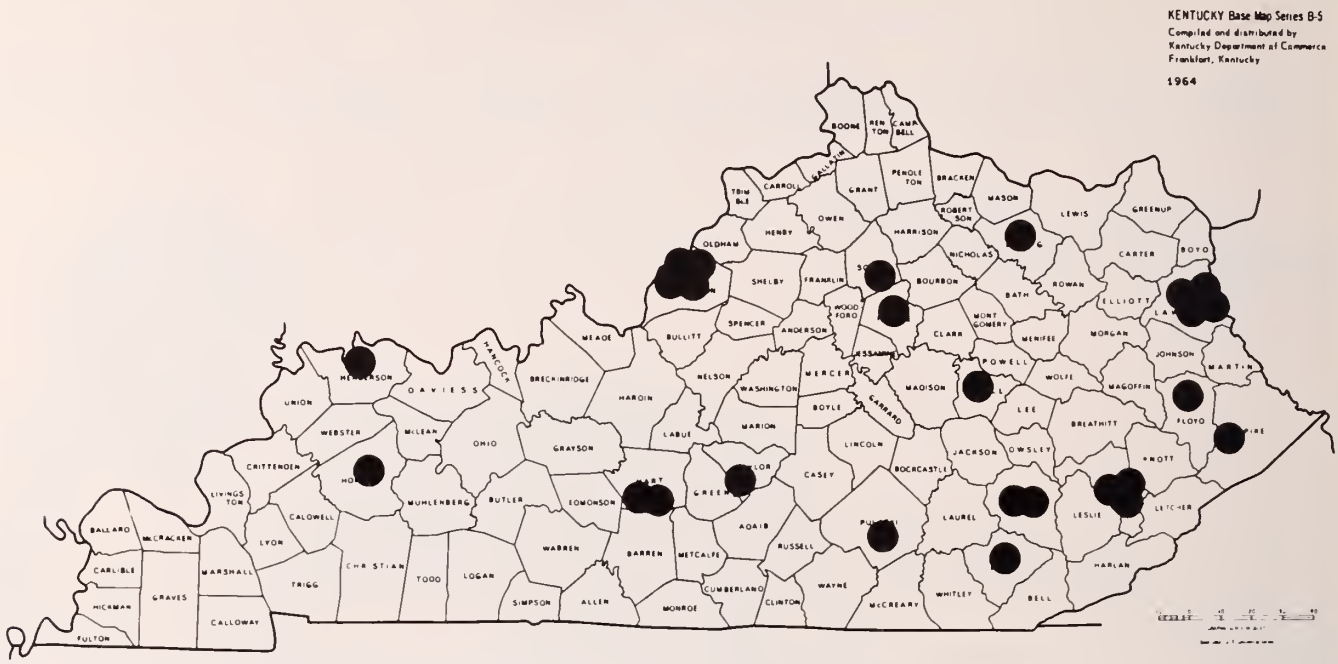


Fig 1. Copperhead bites reported to the Kentucky Regional Poison Center by county location, 1986.

Fifteen patients (57.8%) were hospitalized, principally for observation. The average hospital stay was 3.4 days, with a range of one to seven days.

As hospital charts were not reviewed for this study, treatment information has been gleaned from Poison Center records and, therefore, may not be complete for all cases.

In three cases (11.5%) first aid was administered on-site in the old Boy Scout "ligature-cut-suck" fashion. Typically, when evaluated by health care personnel, the bite site was cleaned and warm compresses were applied. Tetanus immunization status was verified and updated when indicated. Baseline laboratory data (including complete blood count, electrolytes, blood urea nitrogen, coagulation studies and urinalysis) were collected in many cases. Follow-up laboratory data was collected in some cases. One patient was noted to have a slight elevation in his prothrombin time. All other laboratory values were within the normal range. Narcotic pain medication was administered in at least three cases (11.5%). Antibiotics were given in at least five cases (19.2%). Antivenin was given in two cases (7.9%), and an additional patient was skin tested with antivenin.

Systemic effects possibly attributable to envenomation were noted in only one patient (coincidentally the same patient received antivenin).

Parenthetically, two copperhead "incidents" were omitted from the survey: a bite to a dog's snout was reported (the dog did well); as was a case in which some "green stuff" splattered into the eye of a curious motorist who watched outside his car window as he ran over a copperhead.

Management of Copperhead Snake Bites

Snakebite envenomation requires immediate medical evaluation. While each bite must be individually assessed, it should be noted that copperhead bites rarely produce major symptoms. As a result, conservative management, without the use of *Antivenin Crotalidae Polyvalent®*, is usually adequate. The indiscriminate use of antivenin should be discouraged because of high risk of anaphylactoid and serum sickness type reactions. Serum sickness occurs in more than 75% of those receiving antivenin and can be severe. The extent of symptoms depend on many factors including time, location of bite, health of the patient, and the amount of venom injected. It is estimated that as many as 50% of copperhead bites involve little or no envenomation.

The following treatment protocol used by the Kentucky Regional Poison Center is offered as a guide to the treating physician. Parts of this protocol have been modeled on the general pit viper management protocol

TABLE 1
SNAKEBITES REPORTED TO THE KENTUCKY REGIONAL POISON CENTER, 1984-86

Species	1984	1985	1986
Copperhead	15	20	26
Cottonmouth	1	0	1
Rattlesnake	2	3	1
Unknown, presumed poisonous	16	34	50
Unknown, presumed nonposionous	9	9	13
Total	43	66	91

TABLE 2
COPPERHEAD BITES REPORTED TO THE KENTUCKY REGIONAL POISON CENTER BY MONTH, 1986

June	5
July	7
August	5
September	6
October	2
November	1
	26

proposed by the Scientific Advisory Committee of the American Association of Poison Control Centers.[6]

I. Prehospital Treatment
   A. Keep patient quiet and calm.
   B. Apply a loose constricting band above the bite site. Loosen as swelling increases.
   C. Incision with suction may remove a significant amount of venom if done properly within 15 minutes of bite.[7,8]
   D. Transport to medical facility.

II. Initial Hospital Assessment
   A. Identify the origin of the injury—venomous versus nonvenomous snake, insect scratch or puncture wound from other source (see Fig 2 for distinguishing characteristics of pit vipers).
   B. Establish time and sequence of clinical manifestations.
      1. Local—pain, edema, erythema, bleeding, ecchymosis and lymphangitis.
      2. Systemic—weakness, sweating or chills, nausea and/or vomiting, hypotension, cardiac dysrhythmias, perioral and/or peripheral paresthesias, change in taste sensation, seizures, muscle fasciculations, and evidence of hemorrhage.
   C. Grade of envenomation.
      1. Minimal envenomation.
         a. Manifestations remain confined to or around the bite site.
         b. No systemic signs or symptoms.
         c. No laboratory abnormalities.
      2. Moderate envenomation.
         a. Manifestations extend beyond immediate bite area.

TABLE 3
COPPERHEAD BITES REPORTED TO THE KENTUCKY REGIONAL POISON CENTER BY TIME OF DAY, 1986*

0001-0200	0
0201-0400	0
0401-0600	1
0601-0800	0
0801-1000	0
1001-1200	7
1201-1400	1
1401-1600	2
1601-1800	4
1801-2000	3
2001-2200	5
2201-2400	1
	24

* Two cases did not have time of day noted on report.

TABLE 4
COPPERHEAD BITES REPORTED TO THE KENTUCKY REGIONAL POISON CENTER BY AGE OF VICTIM, 1986*

0-5	7
6-10	0
11-15	0
16-20	1
21-25	2
26-30	5
31-35	4
36-40	0
41-50	1
51-60	0
61-70	0
71-75	1
76-80	1
81-85	1
	23

* In three cases no specific age was given; the victim however was known to be an adult.

TABLE 5

SUMMARY OF COPPERHEAD BITE CASES REPORTED TO THE KENTUCKY REGIONAL POISON CENTER, 1986.

DATE AND TIME OF BITE		COUNTY	AGE (YEARS)	SITE OF BITE	TIME BEFORE MEDICAL ATTENTION (HOURS)	INITIAL SYMPTOMS ON PRESENTATION	HOSPITALIZED	LENGTH OF STAY (DAYS)
6-03-86	1950	Scott	28	finger	0.5	one fang mark, erythema at site	no	–
6-07-86	1750	Lawrence	83	finger	1.0	ecchymosis and edema at site, mild pain	yes	4
6-14-86	2032	Perry	5	lateral foot	1.0	1.5 cm diameter ecchymosis at site, moderate pain	yes	1
6-16-86	1845	Taylor	21	wrist	0.25	mild erythema, edema at site	no	–
6-22-86	1030	Hart	43	1" above knee	1.25	"blue discoloration" about wound	yes	1
7-02-86	0645	Hart	78	ankle	2.0	one fang mark, minimal swelling at site	yes	2
7-02-86	1644	Lawrence	32	dorsal hand	0.5	none	no	–
7-04-86	2120	Jefferson	35	ankle	0.25	slight edema at site	no	–
7-11-86	1158	Fleming	24	leg	0.50	two fang marks, slight oozing of serous fluid at site, mild ecchymosis, no edema	yes	2
7-16-86	2200	Estill	29	foot	0.25	two fang marks, 1 cm erythema, minimal swelling at site	yes	4*
7-20-86	1100	Jefferson	3	hand	1.50	mild swelling to three middle digits, moderate pain	yes	2
7-30-86	2356	Pike	20	ankle	2.0	slight ecchymosis at site, marked swelling (2 cm greater than unaffected ankle)	yes	4
8-22-86	1135	Jefferson	A+	fingertip	0.5	two fang marks, no discoloration or edema	no	–
8-26-86	1930	Pulaski	3	ankle	1.50	three bite marks, 1 cm ecchymosis at site, mild swelling	yes	3
8-26-86	2010	Lawrence	3	hand	0.25	scratch	no	–
8-27-86	1140	Lawrence	35	hand	3.0	1 cm area of ecchymosis at site, edema to wrist, moderate pain, nausea, vomiting	yes	3
8-28-86	- - - -	Jefferson	A+	hand	36.0	swelling to elbow, tender axillary lymphadenopathy, slight bluish tint at site	no	–
9-02-86	1100	Perry	3	finger	1.0	ecchymosis at site, slight swelling, pale digit with poor capillary refill, moderate pain	yes	6*
9-04-86	1428	Henderson	5	toe	1.0	ecchymosis at site and dorsum of foot, slight swelling	yes	3
9-04-86	1945	Floyd	32	thumb	1.0	slight swelling	no	–
9-10-86	2246	Hopkins	29	thumb	1.0	slight swelling	yes	1
9-13-86	1430	Clay	30	finger	2.0	slight edema, bruising from tourniquet	yes	3
9-20-86	1630	Perry	4	finger	0.75	one fang mark, ecchymosis at site, mild edema to wrist	yes	3
10-01-86	1228	Grayson	75	hand	0.5	mild swelling	yes	6
10-01-86	- - - -	Clay	30	5" above ankle	10 days	1 cm area of ecchymosis at site, moderate edema, cellulitis	no	–
10-23-86	1100	Jefferson	A+	thumb	- - - -	patient apparently intoxicated, ecchymosis at wrist, swelling of fingers	no	–

+ - means adult, no age was given * - received antivenin – unknown or not applicable

b. Significant systemic signs and symptoms.
c. Laboratory abnormalities.

3. Severe envenomation.
a. Manifestations involve entire extremity.
b. Serious systemic signs and symptoms.
c. Major laboratory abnormalities.

D. Laboratory evaluation.
The following laboratory tests should be part of the initial evaluation of all patients and should be repeated daily or as indicated in hospitalized patients:
1. CBC.
2. Coagulation profile (PT, PTT, fibrinogen, platelet count).
3. Urinalysis.
4. Type and hold blood for moderate to severe envenomations.

III. Hospital Treatment

Patients with symptoms of a moderate or severe envenomation require hospitalization for treatment and observation. Patients with no evidence of envenomation or signs and symptoms consistent with only a minimal envenomation can be observed for four to six hours in the emergency department and then released with appropriate follow-up.

A. Local wound care.
1. Clean with soap and water.
2. Apply warm packs.
3. Position involved extremity slightly below heart level.

B. Pharmacologic treatment.
1. Tetanus prophylaxis as required.
2. Analgesics as necessary.
3. Antivenin for moderate to severe bites only (note: DO NOT SKIN TEST UNLESS ANTIVENIN IS TO BE USED—IT CAN SENSITIZE THE PATIENT AND CAUSE ALLERGIC REACTIONS):
a. Skin test following directions on package insert.
b. Dose: 6–12 vials of *Crotalidae Antivenin Polyvalent*® for adults, 4–6 vials for children.
c. Administration: dilute each vial in 25–50 ml of diluent and administer by IV continuous infusion. Keep epinephrine, diphenhydramine, and corticosteriods at bedside. Begin at a slow rate, if tolerated give at 15 min/vial.
4. Antibiotics (prophylactic use is controversial).

C. Supportive care.
1. Measure limb circumference and assess vascular status frequently.
2. For further information on the treatment of systemic symptoms contact the Kentucky Regional Poison Center.

IV. Contraindicated Treatment

A. Ice or cold packs—increases local tissue damage.
B. Tourniquet—increases tissue damage.
C. Fasciotomy—of no value unless a true compartment syndrome develops (rare).

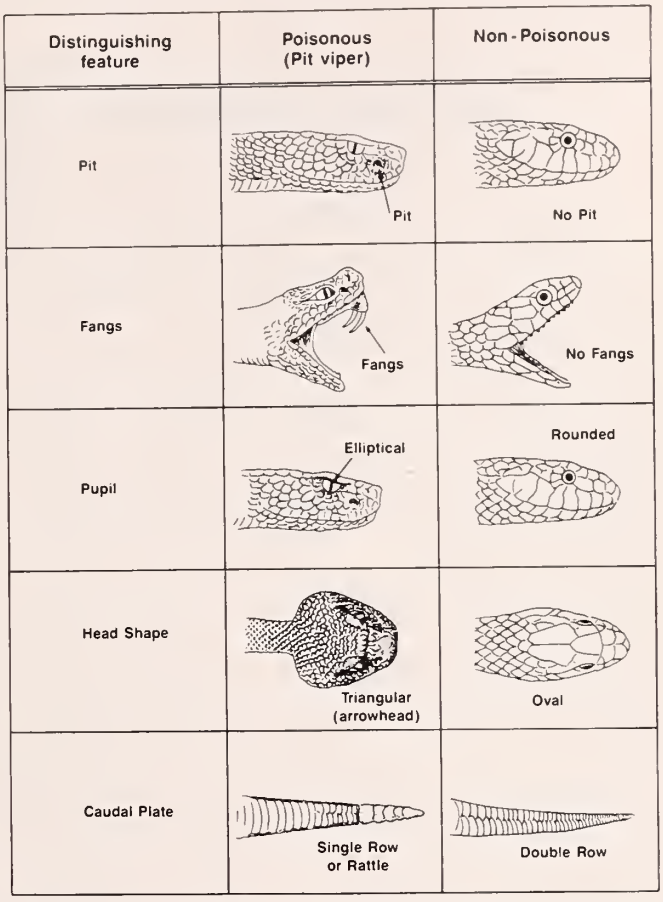


Fig 2. Distinguishing characteristics of poisonous and nonpoisonous snakes (from Arena JM, Drew RH [eds.]. *Poisoning—Toxicology, Symptoms, Treatments*, 5th ed. Springfield, Chas. C. Thomas Publisher, 1986, p. 739).

D. Corticosteroids—of value only in treatment of allergic reactions to antivenin.
E. Heparin for coagulopathies—venom contains anticoagulants.

Conclusion

Copperhead bites remain a significant health problem in Kentucky. The hazards of venomous snakebite are omnipresent—while most bites are reported from rural counties, copperheads also thrive in urban areas. Rapid and appropriate treatment can minimize the risk of morbidity and mortality. The Kentucky Regional Poison Center is available 24 hours a day to assist the medical professional in the management of these cases.

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Site-Specific Cancer Mortality Among Kentucky Residents, 1971–1985

Carl W. Spurlock, PhD

Age-adjusted site-specific cancer mortality rates over the 15-year period 1971 through 1985 have been calculated and analyzed in order to identify trends in Kentucky. Among Kentucky men there was an age-adjusted total cancer death rate increase of 12.7% over this time period, with the greatest site-specific percentage increases in cancer mortality seen with skin cancer (42.4%), lung cancer (32.7%), and multiple myeloma (25.0%). Among Kentucky women there was a smaller increase (5.8%) in age-adjusted total cancer mortality, which was completely accounted for by a startling 90.5% increase in the rate of lung cancer mortality. A dramatic decline in death from cancer of the uterine cervix and a strong decline in stomach cancer deaths among both sexes are other significant changes that were observed. The implications of these findings are discussed within a cancer risk prevention context.

From the Division of Epidemiology, Department for Health Services, Commonwealth of Kentucky, 275 East Main Street, Frankfort, Kentucky 40621.

Cancer incidence rates for Kentucky are imprecisely known because there is no statewide population-based cancer registry. In an attempt to assess trends in incidence, the age-adjusted, site-specific cancer mortality rates over the 15-year period 1971 through 1985 have been calculated and analyzed in order to identify these trends. A previous publication by Hinds et al analyzed cancer mortality trends in Kentucky during the 1971 to 1980 period.[1] This report extends that analysis with an additional five years of data.

In general, cancer mortality rates are a function of both cancer incidence and cancer survival. For cancer sites that are associated with a short survival period after diagnosis (ie, median survival time of less than one year), the mortality rate is a good estimator of the incidence rate. The greater the average time lapse between diagnosis and death from cancer at a particular site (or from any other chronic disease), the more problems there are with the use of the mortality rate to estimate the incidence rate. Not only is it difficult to estimate incidence in absolute terms from mortality data, but it is also difficult to use cancer mortality rates from two different populations to estimate the relative cancer incidence in those populations. This is because survival characteristics often differ between population groups. However, where the survival times for cancer sites have not changed markedly from one time period to another, it is possible with reasonable accuracy to estimate trends in incidence in a single population by calculating trends in mortality. The usual requirements for consideration of age and sex differentials in incidence and mortality apply, but where the population base of these calculations is otherwise stable, mortality trends represent an accessible means to assess cancer risk trends for a population not served by a cancer incidence registry.

TABLE 1

CANCER DEATHS AND AVERAGE ANNUAL AGE-ADJUSTED CANCER MORTALITY RATES PER 100,000 KENTUCKY MEN, BY SITE AND TIME PERIOD

CANCER SITE	1971-1975 DEATHS (Unadjusted)	1971-1975 RATE (Age-adjusted)	1976-1980 DEATHS (Unadjusted)	1976-1980 RATE (Age-adjusted)	1981-1985 DEATHS (Unadjusted)	1981-1985 RATE (Age-adjusted)	PERCENT CHANGE IN AGE-ADJUSTED RATES* 1971-75 TO 1976-80	1976-80 TO 1981-85	1971-75 TO 1981-85
TOTAL	15,677	206.1	17,829	220.5	20,128	232.2	+7.0	+5.3	+12.7
Lung and bronchus	5,337	70.0	6,707	83.7	8,066	92.9	+19.6	+11.0	+32.7
Colon	1,408	18.6	1,586	19.5	1,875	21.7	+4.8	+11.3	+16.7
Prostate	1,458	19.5	1,613	19.6	1,825	21.2	+0.5	+8.2	+8.7
Pancreas	841	11.1	953	11.8	901	10.4	+6.3	−11.9	−6.3
Leukemias	627	8.2	736	9.0	747	8.5	+9.8	−5.6	+3.7
Lymphomas	552	7.2	523	6.4	599	6.9	−11.1	+7.8	−4.2
Stomach	648	8.6	572	7.1	561	6.5	−17.4	−8.5	−24.4
Bladder	434	5.7	494	6.1	534	6.2	+7.0	+1.6	+8.8
Brain/Nervous System	391	5.0	418	5.2	480	5.4	+4.0	+3.8	+8.0
Kidney	335	4.4	356	4.4	466	5.4	0.0	+22.7	+22.7
Esophagus	382	5.0	401	5.0	448	5.2	0.0	+4.0	+4.0
Skin	251	3.3	349	4.2	410	4.7	+27.3	+11.9	+42.4
Rectum	345	4.6	333	4.1	315	3.6	−10.9	−12.2	−21.7
Multiple Myeloma	209	2.8	222	2.8	301	3.5	0.0	+25.0	+25.0
Liver	282	3.7	278	3.4	266	3.1	−8.1	−8.8	−16.2
Larynx	245	3.2	281	3.5	257	3.0	+9.4	−14.3	−6.3
All Others	1,932	25.2	2,007	24.7	2,077	23.8	−2.0	−3.6	−5.6

*$\frac{\text{(Rate of Later Time Period)} - \text{(Rate of Earlier Time Period)}}{\text{(Rate of Earlier Time Period)}} \times 100 = \text{Percent Change.}$

Methods

Cancer deaths among Kentucky residents during 1971 to 1985 were identified from death certificate data provided by the Vital Statistics Branch of the Kentucky Department for Health Services. Estimates of the population of Kentucky in each year from 1971–1985 were obtained from the Urban Studies Center, University of Louisville. Average annual age- and sex-specific cancer mortality rates per 100,000 population were calculated for three 5-year time periods: 1971 to 1975; 1976 to 1980; and 1981 to 1985. Summary age-adjusted mortality rates were derived using the direct method, with the 1970 US population as a standard.[3] Five-year time periods, rather than a shorter interval, were chosen to ensure sufficient numbers of cases in the 20 major cancer site categories so that statistically stable rates could be derived. Race-adjusted and race-specific rates are not reported because the relatively small number of cancer deaths among nonwhite Kentuckians produced statistically unstable rates even for the major site categories.

Cancer diagnoses on death certificates were coded by a nosologist in the Kentucky Health Statistics Branch according to the Eighth (1971 to 1978) and Ninth (1979 to 1985) revisions of the International Classification of Diseases. These codes were grouped into cancer sites in a manner that conforms with the methods used by the National Cancer Institute Surveillance, Epidemiology, and End Results Program.[3] Cancer sites for which the annual mortality was less than 25 individuals were not computed because the rates yielded were deemed too unstable for analysis.

Cancer mortality risk for the three time periods was compared in two ways. First, the change (either positive or negative) in the age-adjusted, sex-specific average rate was expressed as a percentage of the rate for the preceding five-year period and as a percentage of the rate in the 1971 to 1975 base period. Second, the observed sex- and site-specific cancer deaths in the 1981–85 time period were compared to expected deaths for that time period had the average annual age- and sex-specific rates for each site from the 1976–80 time period continued in the 1981–85 period. A Poisson probability distribution, applied with a 95% confidence interval, was used to determine the probability that the difference between the observed and expected deaths was merely the product of chance variations.

TABLE 2

CANCER DEATHS AND AVERAGE ANNUAL AGE-ADJUSTED CANCER MORTALITY RATES PER 100,000 KENTUCKY WOMEN, BY SITE AND TIME PERIOD

CANCER SITE	1971-1975 DEATHS (Unadjusted)	1971-1975 RATE (Age-adjusted)	1976-1980 DEATHS (Unadjusted)	1976-1980 RATE (Age-adjusted)	1981-1985 DEATHS (Unadjusted)	1981-1985 RATE (Age-adjusted)	PERCENT CHANGE IN AGE-ADJUSTED RATES* 1971-75 TO 1976-80	1976-80 TO 1981-85	1971-75 TO 1981-85
TOTAL	12,624	134.0	14,162	137.1	16,343	141.9	+2.3	+3.5	+5.8
Lung and bronchus	1,345	14.8	2,080	21.3	3,069	28.2	+43.9	+32.3	+90.5
Breast	2,196	24.0	2,397	24.1	2,806	25.6	+0.4	+6.2	+6.6
Colon	1,769	17.9	2,000	18.2	2,139	17.3	+1.7	−4.9	−3.3
Ovary	748	8.1	779	7.8	878	7.9	−3.7	+1.2	−2.4
Pancreas	645	6.6	786	7.3	870	7.1	+10.6	−2.7	+7.5
Leukemias	507	5.4	503	4.8	581	4.9	−11.1	+2.0	−9.2
Lymphomas	384	4.1	461	4.4	571	4.8	+7.3	+9.0	+17.0
Cervix Uteri	668	7.5	525	5.5	495	4.7	−26.7	−14.5	−37.3
Corpus/Uterus NOS†	474	5.1	475	4.5	476	4.1	−11.8	−8.8	−19.6
Brain/Nervous System	338	3.9	328	3.5	422	3.9	−10.3	+11.4	0.0
Stomach	444	4.5	446	4.0	396	3.3	−11.1	−17.5	−26.6
Rectum	335	3.4	269	2.4	298	2.5	−29.4	+4.0	−26.4
Kidney	225	2.4	232	2.2	255	2.2	−8.3	0.0	−8.3
Multiple Myeloma	192	2.0	225	2.1	253	2.1	+5.0	0.0	+5.0
Skin	193	2.0	219	2.0	237	2.0	0.0	0.0	0.0
Bladder	228	2.2	241	2.1	237	1.8	−4.5	−14.2	−18.1
Liver	218	2.3	207	2.0	191	1.6	−13.0	−20.0	−30.4
All Others	1,715	17.8	1,989	18.9	2,169	17.9	+6.2	−5.2	+0.5

*$\frac{\text{(Rate of Later Time Period)} - \text{(Rate of Earlier Time Period)}}{\text{(Rate of Earlier Time Period)}} \times 100 = \text{Percent Change.}$

† NOS = Not Otherwise Specified.

Results

Tables 1 and 2 show the average annual age-adjusted, sex- and site-specific cancer death rate per 100,000 Kentuckians for three 5-year periods: 1971–75; 1976–80; and 1981–85. The sites are arranged in order of decreasing mortality during the 1981–85 period. Total cancer deaths for men increased from 15,677 during the 1971–75 period to 20,128 during the 1981–85 period (Table 1). This 28.4% increase in the crude mortality yields a 12.7% increase when changes in the size and age-distribution of Kentucky's male population between these periods were taken into account. The crude cancer mortality among Kentucky women increased 29.5% between 1971–75 and 1981–85; this translates to a 5.8% increase in total cancer mortality among women when changes in population size and age distribution between these periods were taken into account.

Between 1971–75 and 1981–85, percentage increases in average age-adjusted annual cancer mortality rates among men (Table 1) were greatest for skin (42.4%), lung and bronchus (32.7%), and multiple myeloma (25.0%). The greatest absolute increase in mortality was for cancer of the lung and bronchus (an average of 546 more lung cancer deaths per year in 1981–85 than in 1971–75). The average mortality increase for lung cancer in men accounted for 61% of the average increase in total male cancer mortality and for 88% of the increase in the age-adjusted mortality rate. By contrast, several cancer sites showed substantial decreases in average male age-adjusted annual mortality between 1971–75 and 1981–85. Stomach cancer mortality declined 24.4%, rectal cancer mortality declined 21.7% and mortality attributed to primary liver cancer declined 16.2%.

Among Kentucky women (Table 2) there was a smaller increase (5.8%) in the average annual age-adjusted total cancer mortality rate between 1971–75 and 1981–85 than that observed among Kentucky men. However, there were substantial changes in the age-adjusted rates for several sites among women. There was a startling 90.5% increase in average annual age-adjusted lung cancer mortality. This translates to 345 more deaths per year from lung cancer among Kentucky women in the 1981–85 period than were observed in the 1971–75 period. Other cancer sites having substantial increases among women were lymphoma

TABLE 3

OBSERVED 1981-1985 CANCER DEATHS AND EXPECTED DEATHS FOR THE SAME TIME PERIOD GIVEN AGE-, SEX-, AND SITE-SPECIFIC MORTALITY RATES DURING 1976-1980

CANCER SITE	MEN			WOMEN		
	OBSERVED	EXPECTED	P*	OBSERVED	EXPECTED	P*
Lung and bronchus	8,066	7,250	<.001	3,069	2,264	<.001
Breast	N/A	N/A	N/A	2,806	2,625	<.001
Colon	1,875	1,699	<.001	2,139	2,322	.050
Prostate	1,825	1,694	.002	N/A	N/A	N/A
Pancreas	901	1,024	<.001	870	879	.778
Lymphoma	599	565	.160	571	510	.008
Stomach	561	611	.044	396	500	<.001
Cervix Uteri	N/A	N/A	N/A	495	577	<.001
Corpus/Uterus NOS†	N/A	N/A	N/A	476	539	.006
Rectum	315	359	.020	298	301	.892
Liver	266	300	.050	191	229	.012
Kidney	466	382	<.001	255	256	.984
Multiple Myeloma	301	240	<.001	253	251	.916
Bladder	534	528	.810	237	270	.044

* Probability (two-tailed) of the observed number of deaths in 1981-1985 given the expected number.
†NOS = Not Otherwise Specified.

(17.0%), pancreas (7.5%), and breast (6.6%). Sites which had substantial decreases in age-adjusted mortality rates included cervix uteri (−37.3%), liver (−30.4%), stomach (−26.6%), rectum (−26.4%), corpus uteri (−19.6%), and bladder (−18.1%).

Table 3 presents the results of a statistical analysis designed to assess the likelihood that observed changes in death rates were attributable simply to chance variations in the number of deaths between periods. Changes between the 1976–80 and the 1981–85 periods were chosen for analysis because analyzed changes between the 1971–75 and the 1976–80 periods have been reported in a previous publication[1] and because it was desirable to assess the significance of the more recent changes. Statistically significant excess deaths were observed in the 1981–85 time period among men for cancer of the lung and bronchus, colon, kidney, multiple myeloma and prostate, and among women for cancer of the lung and bronchus, breast and lymphomas. Significantly fewer deaths were observed than expected for cancer of the pancreas, rectum, stomach, and liver among men. Among women, significantly fewer deaths were observed than expected for cancer of the stomach, cervix uteri, corpus uteri, liver, bladder, and colon.

Table 4 contains the percentage change in average annual lung cancer mortality for men and women between 1971–75 and 1981–85, by five-year age group. While there is a decline in the lung cancer mortality rate for men aged 35–54, those older than 54 had consistently increased lung cancer mortality. For every age group considered, women showed a smaller age-specific rate decrease or a larger rate increase in lung cancer mortality than was seen among men.

Table 5 contains mortality rate changes by age group for breast cancer. All below 50 age groups, with the exception of the 35–39 age group, had decreases in breast cancer mortality between the 1971–75 and 1981–85 time periods. Above age 50, age-specific mortality due to breast cancer increased for all age groups between 1971–75 and 1981–85.

Discussion

During the past 30 years national mortality rates for cancer of all sites increased slightly for men and, in 1969, began increasing for women.[5] Lung cancer has shown a dramatic increase among both sexes, with the current rate of increase higher for women than men. If it were not for the increase in lung cancer mortality over the last 30 years, it is generally accepted that age-adjusted cancer mortality in the United States would have changed little or even declined. The accelerating death rates due to lung cancer among women are particularly distressing because they have tended to obscure the gains made in other areas of cancer prevention and treatment for women. It had been anticipated for some time that lung cancer would replace breast cancer as the leading cause of cancer death among US women. The American Cancer Society estimates this occurred at the national level in 1986.

TABLE 4

AVERAGE ANNUAL AGE-SPECIFIC LUNG CANCER MORTALITY RATES PER 100,000 BY SEX AND TIME PERIOD

AGE GROUP	MEN 1971-75 RATE	MEN 1976-80 RATE	MEN 1981-85 RATE	MEN PERCENT CHANGE* (1971-75 to 1981-85)	WOMEN 1971-75 RATE	WOMEN 1976-80 RATE	WOMEN 1981-85 RATE	WOMEN PERCENT CHANGE* (1971-75 to 1981-85)
35 - 39	9.6	8.6	7.4	−22.9	4.3	4.4	4.1	−4.6
40 - 44	29.8	28.8	20.9	−29.8	12.6	16.2	13.2	+4.7
45 - 49	74.1	67.3	68.2	−7.9	22.9	35.8	33.9	+48.0
50 - 54	153.3	155.9	131.1	−3.1	38.7	50.9	55.8	+44.1
55 - 59	191.5	240.7	248.3	+29.6	49.4	67.1	82.4	+66.8
60 - 64	290.1	345.0	371.8	+28.1	50.3	78.0	119.6	+137.7
65 - 69	360.0	422.0	498.5	+38.4	51.5	83.7	141.4	+174.5
70 - 74	380.4	514.8	567.7	+49.2	58.5	84.2	136.9	+134.0
75 - 79	337.7	433.0	585.7	+73.4	58.1	88.1	108.6	+86.9

$$*\frac{(1981 - 1985\ \text{Rate}) - (1971 - 1975\ \text{Rate})}{(1971 - 1975\ \text{Rate})} \times 100 = \text{Percent Change}$$

TABLE 5

AVERAGE ANNUAL AGE-SPECIFIC BREAST CANCER MORTALITY RATES PER 100,000 KENTUCKY WOMEN IN THREE TIME PERIODS

AGE GROUP	RATES 1971-75	RATES 1976-80	RATES 1981-85	PERCENT CHANGE 1971-75 TO 1976-80	PERCENT CHANGE 1976-80 TO 1981-85	PERCENT CHANGE 1971-75 TO 1981-85
25 - 29	1.9	2.0	0.9	+5.3	−65.0	−63.2
30 - 34	7.1	6.0	6.8	−15.5	+13.3	−4.2
35 - 39	10.8	12.2	15.5	+13.0	+27.0	+43.5
40 - 44	25.3	20.2	23.0	−20.2	+13.9	−9.1
45 - 49	42.0	39.2	34.6	−6.7	−11.7	−17.6
50 - 54	54.2	56.9	55.2	+5.0	−3.0	+1.8
55 - 59	60.4	65.7	73.3	+8.8	+11.6	+21.4
60 - 64	72.0	69.7	81.9	−3.2	+17.5	+13.8
65 - 69	77.1	82.6	91.5	+7.1	+10.9	+18.8
70 - 74	97.2	96.2	94.8	−1.0	−1.5	+2.5
75 - 79	111.0	125.0	116.0	+12.6	−7.2	−4.5

The findings for cancer mortality among Kentucky residents during the period 1971 to 1985 are generally comparable to trends which have been observed in the total US population. One exception is that in 1981 lung cancer surpassed breast cancer as the leading cause of cancer mortality among Kentucky women[7] and has retained that position ever since. The 90.5% increase in the annual age-adjusted lung cancer mortality rate among Kentucky women (Table 2) accounts for all of the increase in the total female cancer mortality rate. The 6.6% increase in age-adjusted breast cancer mortality in Kentucky between 1971–75 and 1981–85 is similar to the national experience. There are, however, differences in the age distribution of the increase when Kentucky data are compared to national figures. Nationally most of the increase was accounted for by women over age 50, while in Kentucky there were increases both above and below age 50 (Table 5). The reason for this difference in age-distributed mortality is unclear.

Several cancer sites showed significantly decreased mortality for women over the study period; these included stomach, liver, bladder, cervix uteri and corpus uteri (Table 3). The continuing reduction in cervical cancer mortality among all age groups of Kentucky women is particularly gratifying, as it is temporally associated with the greater use of screening programs designed to detect this disease at an early stage where effective treatment is possible. Unfortunately, cervical cancer remains a far greater reason for cancer mortality in Kentucky (where it accounts for 5.9% of female cancer mortality) than in the US (4% of female cancer mortality). These facts reinforce the need for continuing effort to improve screening practices in

Kentucky, and for continuing research into how our preventive efforts can become more effective.

Among Kentucky men, the single largest site-specific percentage increase (42.4%) between 1971–75 and 1981–85 was for skin cancer. The incidence rate for skin cancer at the national level has been strongly increasing over the same period.[10] Similar trends have been observed in Canada and the United Kingdom.[11] This rate of increase in national skin cancer mortality has been approximately the same as that observed in Kentucky over the 15-year study period. The current percentage of total cancer deaths resulting from skin cancer among Kentucky men is exactly the same as among men throughout the US (2%). This increasing death toll from skin cancer is disturbing and indicates the need for increased vigilance by clinicians and better public education about skin protection.

The 25% increase in multiple myeloma mortality among Kentucky men since the 1976–80 period is statistically significant. The absence of a similar increase among Kentucky women suggests that improved diagnostic procedures are not a plausible explanation for the increase. Because nonwhite Americans have been affected by higher myeloma mortality at the national level, race-specific Kentucky rates were calculated for this cancer. Nonwhite Kentucky men had a mortality of 7.9 per 100,000 due to myeloma compared to 5.8 per 100,000 at the national level. The corresponding rates for white men are 3.3 per 100,000 both nationally and in Kentucky. It seems clear that future studies on myeloma in Kentucky and the nation should focus on the nonwhite population.

Lung cancer mortality rates in Kentucky identify a public health problem of the first magnitude. Despite improvements in methods of treatment and early detection, primary prevention remains the foundation of a rational strategy for reducing deaths due to this disease. Although the latency period associated with the pathogenesis of lung cancer makes it difficult to assess the effectiveness of current primary prevention activities, the continuing increase in mortality rates noted by this study strongly suggests that more efforts are needed.

There are a number of factors that have been associated with an increased risk of lung cancer. It is clear, however, that the known risk factor to which Kentuckians are most widely exposed is cigarette smoking. In 1986 respondents to the Kentucky Behavioral Risk Factor Survey indicated that 37.3% of men and 32.2% of women are current cigarette smokers. These figures represent a decrease in smoking prevalence among men and an increase among women when compared to the same survey in 1982. Overall, Kentucky still ranks near the highest among all states in terms of exposure to this risk factor.

Unlike most other risk factors for lung cancer, cigarette smoking is readily apparent, known to the person involved, and can be stopped without a large financial expenditure by the individual. Strategies to reduce lung cancer mortality in Kentucky must either include a strong smoking reduction component or suffer by comparison in both efficacy and cost terms.

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Breast Reconstruction

Gregory L. Brown, MD

Breast cancer is the most common cancer in women with 9% of all women in the United States developing the disease.[1] In 1981, there were 110,000 new cases. Most of these women are treated by mastectomy in one form or another. As a result, many women undergo the physical and emotional trauma associated with breast loss. Recent advances in the surgical techniques of reconstruction offer these women a reasonable means of breast restoration.

Prior to the mid 1970s, there were limited techniques available for breast reconstruction. The primary procedure was direct placement of an implant beneath the skin following mastectomy. After mastectomy, not only is the breast tissue absent but there is a deficit of chest wall skin as well. Therefore, direct implant placement resulted in a tight breast envelope with little natural appearing ptosis.

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During the late 1970s, the introduction of the latissimus dorsi myocutaneous flap for breast reconstruction offered a chance for a more natural appearing breast.[2] This flap provides the necessary skin for a new breast envelope, and the associated muscle and subcutaneous portions of the flap add to the replacement of the breast parenchyma. However, it is almost always necessary to use a breast prosthesis beneath the latissimus flap, because the subcutaneous fat and muscle are limited and adequate projection is difficult to achieve without an implant.

In the early 1980s, Radovan introduced the concept of tissue expansion for breast reconstruction.[3] This technique involves placement of a deflated expander beneath the skin of the mastectomy site. The expander is serially inflated over time so as to increase the surface area of the breast envelope by stretching or expanding overlying skin. Once an adequate volume is obtained, the expander is removed and a permanent implant inserted in the newly created pocket. The rationale is that an overexpanded capsule produced by the expander will result in a more natural appearing contour once the permanent prosthesis is placed. There are inherent problems with expander reconstruction, which include extrusion, infection, and multiple office visits for serial inflation.

In 1982, an important contribution was made towards total autologous breast reconstruction.[4] This development was the introduction of the TRAM (trans-rectus-abdominis myocutaneous) flap, which provides not only the necessary skin for added projection and ptosis but also the soft tissue needed to fashion a breast mound. In most instances, a prosthesis is not necessary. This flap makes use of the natural adipose deposition found

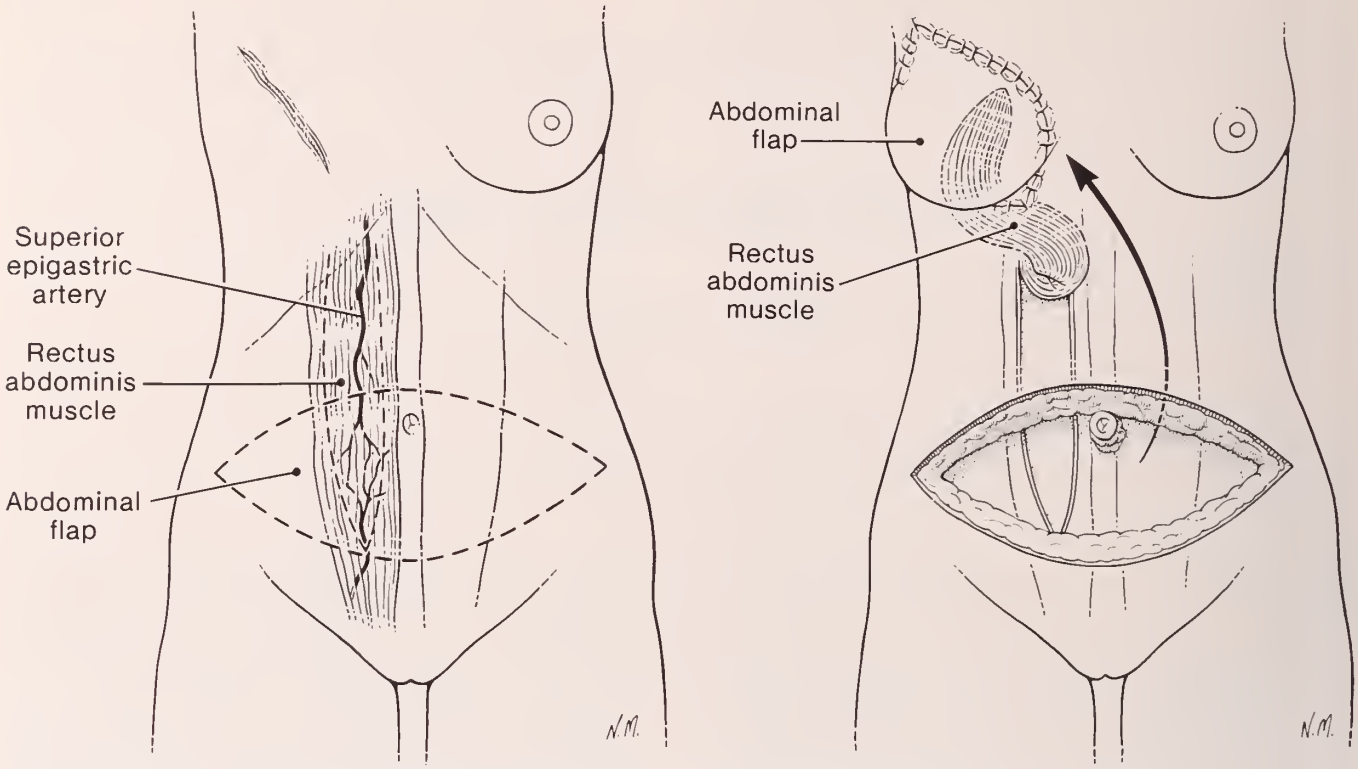


Fig 1 (A) Vascular supply to the TRAM flap. (B) Elevation of the TRAM flap and creation of a breast mound.

in the lower abdomen on most women (Fig 1A). The tissue is vascularized by perforating vessels from the underlying rectus abdominis muscle. The blood supply to this muscle is two-fold, the superior epigastric from cephalad and the inferior epigastric from the rostral direction with arborization of the two systems in the mid-muscle. By using a pedicle flap based superiorly, it is possible to create a breast mound (Fig 1B). In most instances, the subcutaneous fat is sufficient for adequate breast projection (Fig 2).

We have developed an added precautionary technique used in elevating the flap. Because the flap is perfused through the superior epigastric system, the blood supply traverses an arborization at the mid-rectus level producing a somewhat indirect perfusion course to supply the skin and subcutaneous tissue of the flap. At the time of flap elevation, we routinely dissect the inferior epigastric pedicle distally to the femoral vessels so that if the flap shows signs of ischemic changes we can anastomose the inferior epigastric system to an axillary vessel for added perfusion. This anastomosis is performed with the microscope. It is rarely needed; however, the option is an important one for the infrequent flap that develops perfusion problems.

The only real contraindication to the TRAM flap is the asthenic patient with little abdominal soft tissue or the presence of previous subcostal surgical incisions. If the patient has had subcostal incisions, a microvascular transfer of the same flap based on the inferior epigastric vessels to the axilla is indicated. One advantage to the microvascular transfer is that less muscle is required from the abdominal wall with less potential for postoperative abdominal hernia formation.

These newer techniques for breast reconstruction offer the postmastectomy patient the opportunity to have a natural breast. The TRAM flap is often preferred because there is no need for a prosthesis with all of the attendant complications of a foreign body. The added protection of a back-up microvascular anastomosis makes this a safe and effective reconstruction.

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Fig 2 (A and B) A 30-year-old female who underwent a right modified radical mastectomy for infiltrating ductal carcinoma and a left subcutaneous prophylactic mastectomy for cellular atypia.

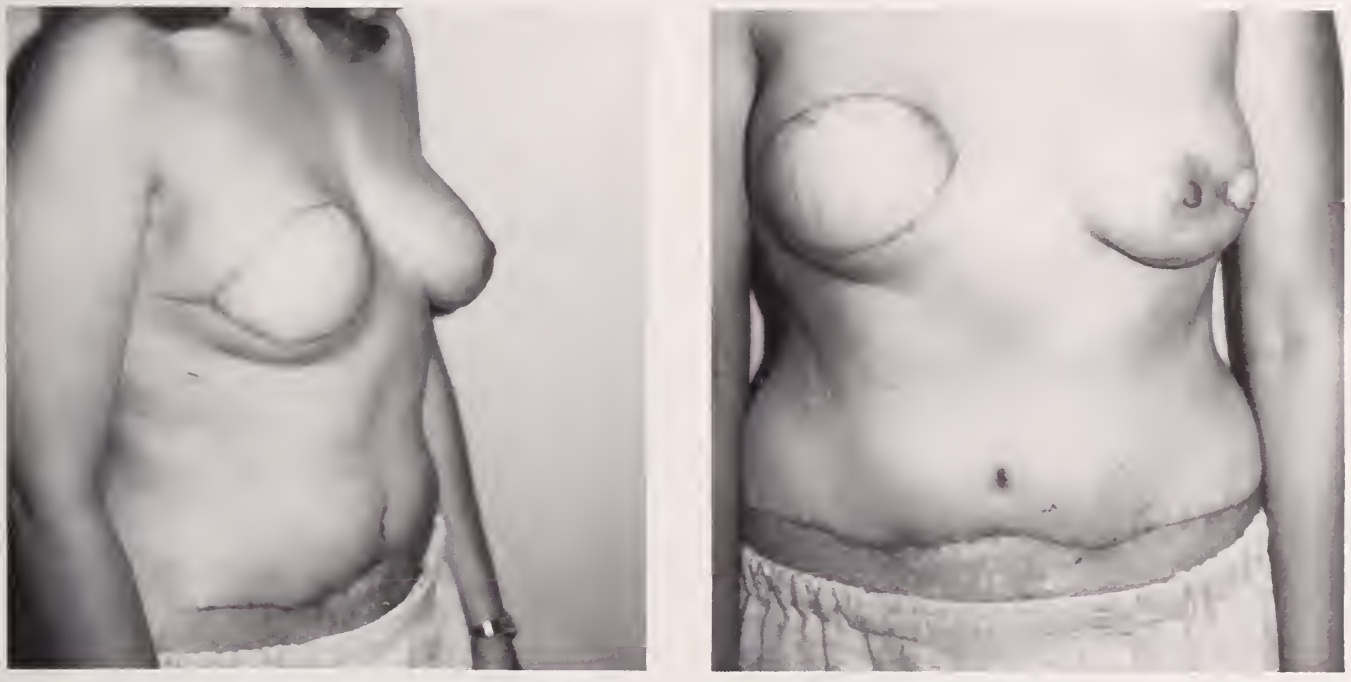


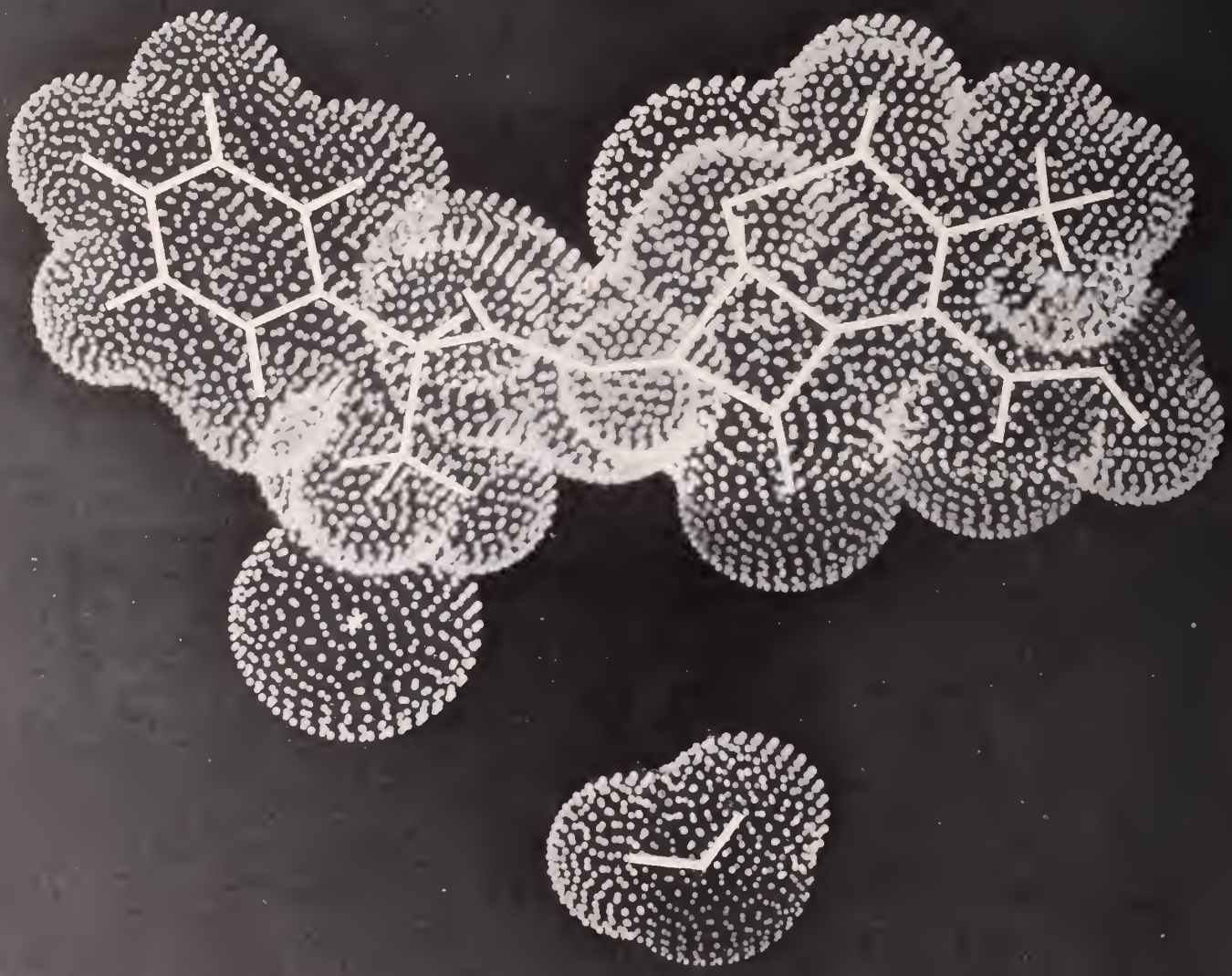
Fig 3 (A and B) She subsequently underwent bilateral TRAM flap reconstruction with a deepithelialized buried paddle on the left. The patient declined right nipple areolar reconstruction. Note the small "skin window" which is used to monitor the perfusion of the buried flap during the early postoperative period.

ANNOUNCING

NEW

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cephalexin hydrochloride monohydrate



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Computer-generated molecular structure of cephalexin hydrochloride monohydrate

Convenient 500-mg b.i.d. dosage and demonstrated effectiveness for treatment of:

- ☐ skin and skin structure infections*
- ☐ uncomplicated cystitis†
- ☐ pharyngitis‡

- New hydrochloride salt form of cephalexin—requires no conversion in the stomach before absorption
- Well-tolerated therapy



- May be taken without regard to meals

For other indicated infections, 250-mg tablets available for q.i.d. dosage

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Keftab is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-sensitive patients.

Penicillin is the drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever.

*Due to susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.
† Due to susceptible strains of *Escherichia coli*, *Proteus mirabilis*, and *Klebsiella* sp.
‡ Due to susceptible strains of group A β-hemolytic streptococci.

KEFTAB™
(cephalexin hydrochloride monohydrate)

Summary: Consult the package literature for prescribing information.

Indications and Usage:

Respiratory tract infections caused by susceptible strains of *Streptococcus pneumoniae* and group A β-hemolytic streptococci.

Skin and skin structure infections caused by susceptible strains of *Staphylococcus aureus* and/or β-hemolytic streptococci.

Bone infections caused by susceptible strains of *S aureus* and/or *Proteus mirabilis*.

Genitourinary tract infections, including acute prostatitis, caused by susceptible strains of *Escherichia coli*, *P mirabilis*, and *Klebsiella* sp.

Contraindication: Known allergy to cephalosporins.

Warnings: KEFTAB SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

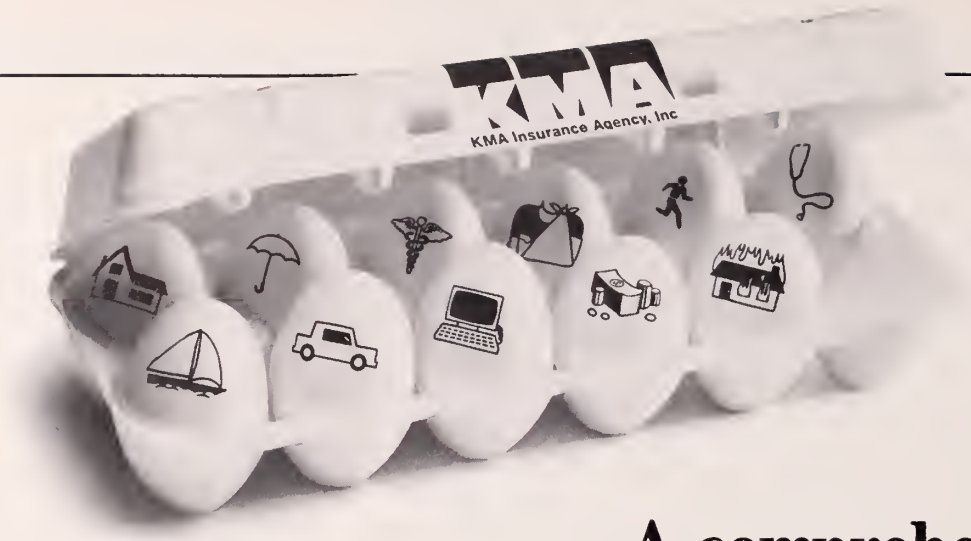
Precautions:

- Discontinue Keftab in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Keftab should be administered cautiously in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy and lactation. Cephalexin is excreted in mother's milk. Exercise caution in prescribing Keftab for these patients.
- Safety and effectiveness in children have not been established.

Adverse Reactions:

- *Gastrointestinal*, including diarrhea and, rarely, nausea and vomiting. Transient hepatitis and cholestatic jaundice have been reported rarely.
- *Hypersensitivity* in the form of rash, urticaria, angioedema, and, rarely, erythema multiforme, Stevens-Johnson syndrome, or toxic epidermal necrolysis.
- *Anaphylaxis* has been reported.
- *Other reactions* have included genital/anal pruritus, genital moniliasis, vaginitis/vaginal discharge, dizziness, fatigue, headache, eosinophilia, neutropenia, and thrombocytopenia; reversible interstitial nephritis has been reported rarely.
- Cephalosporins have been implicated in triggering seizures, particularly in patients with renal impairment.
- *Abnormalities in laboratory test results* included slight elevations in aspartate aminotransferase (AST, SGOT) and alanine aminotransferase (ALT, SGPT). False-positive reactions for glucose in the urine may occur with Benedict's or Fehling's solution and Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

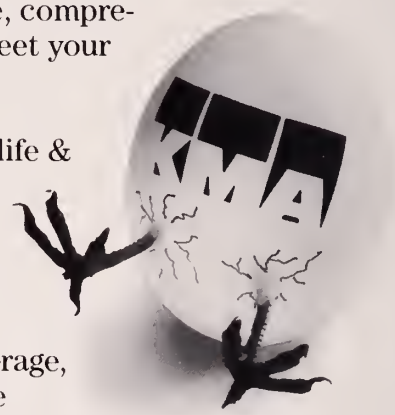
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Why Me?

A small plane crashes. Three young men are killed, their families suddenly bereft, wives without husbands, children without fathers.

A friend lies paralyzed, totally dependent on the physical largesse of others. His only control is breathing. His intellect is untouched by disease; his existence "a vale of tears."

A 12-year-old son of friends dies accidentally, suddenly precipitating his family into the unanswered questions of why him? Why us? Why me?

And each day the march of patients continues with their unsolvable problems: cancer that is terminal, end stage heart failure that no longer responds to medicine, renal failure, respiratory failure, and finally brain failure where one is robbed of faculties but the physical body persists, in seeming perfect harmony with the environment.

"Why me," they cry out. "Why thee and not me" the echo comes back to us. Oh God, we pray, help them but save me. A selfish, egotistical, unrealistic plea, but we all make it, silently, desperately, more often than we care to admit.

So what is the answer? Are some of us destined to suffer, others to go through life comfortably, joyfully, all expectations met? Or, do we all suffer, some in ways not visible to others, in dark nights of the soul that no one can share. The Greeks say that no man can count himself fortunate until he has lived his last day.

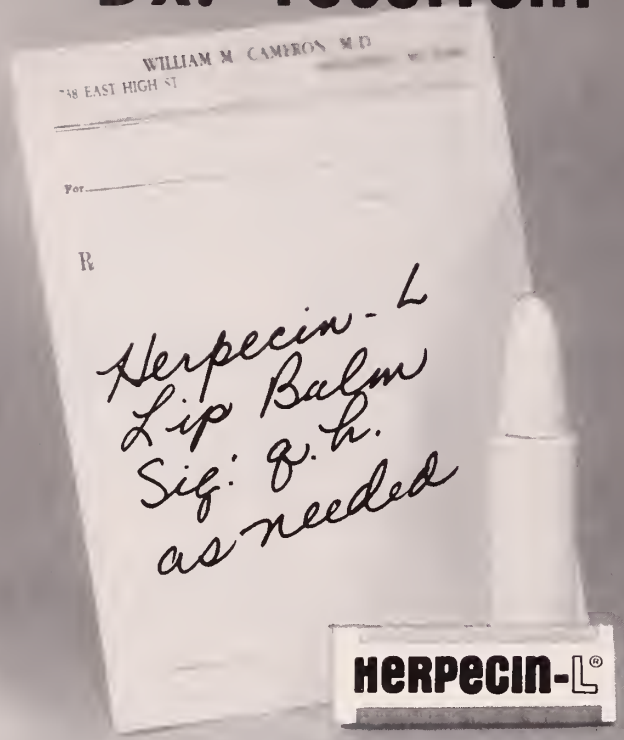
Paul says that "we rejoice in our sufferings, knowing that suffering produces endurance, and endurance produces character and character produces hope and hope does not disappoint us, because God's love has been poured into our hearts through the Holy Spirit which has been given to us."

But this may be the stuff of heroes, or is it? Can we all really hope in the certain expectation of grace? I think so, I know so; but then have I really been tested? Is this the assurance of the untried? We never really know, do we?

The only answer I can give to my patient or to myself is to help as best we can, to persevere in the face of adversity, and finally to be of good cheer — "for in the world you will have tribulation but be of good cheer, for I have overcome the world."

Paul C. Grider, Jr, MD

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AIR FORCE

Our Stubbornness Allowed Us to Deliver a Jewel

Richard S. Wolf, MD

We got our jewel at First and Chestnut. When I say "We," I am talking about the community, the citizens and the physicians. But let me tell you how this story began.

Construction of the Old Medical School Building at First and Chestnut Streets in Louisville, Kentucky, began in 1891. The four-story Bedford Stone ediface, featuring a tower and gargoyles, was finished in 1893. The building was designed in the Richardsonian-Romanesque style by the Louisville firm of Clarke & Loomis at a total cost of $150,000.

From this majestic, old building more than 6,000 medical students and dental students were graduated. The building was abandoned in 1968 when the University of Louisville School of Medicine moved to a new contemporary campus. When the Louisville Board of Education offered to buy and demolish the building to create parking for a nearby trade school in 1976, the Medical Foundation of the Jefferson County Medical Society of Louisville became aware of the historic building's threatened demise. Members took a look at the then decrepit building, and after much discussion, a group of well-meaning, idealistic, and admittedly naive physicians decided they would conduct a restoration project to save the old Medical School building for the community's benefit.

They bought the site from the University of Louisville and the State of Kentucky for $110,000.

Leaders of the County Medical Society Foundation believed they could raise money from local physicians and alumni. They thought with the help of the Heritage Commission, federal government, and local foundations, adequate monies could be raised easily and the building restored.



The tower and copper-topped red tile roof of the Community Health Building at 101 W Chestnut St is a landmark linking Louisville's medical center with the downtown business community.



The old U of L Medical School Building, now called the Community Health Building, is listed on the National Register of Historic Places and has received local preservation awards.



Ornate stone work reflective of its 1893 completion date is visible from the east side of the old U of L Medical School Building, as it faces Interstate 65 in Louisville.

There was no question this was a historic building. As can be seen by the accompanying pictures, the building has been saved and has been restored, but nothing was easy. All our original plans had to be rethought and rethought over and over again.

The end product exceeded the dreams and expectations of anyone involved, but what an unbelievable task it was to restore the building, to collect the funds, and to make the whole project work.

Fortunately all of us who were on the Medical Foundation Board and then on an appointed project steering committee had one asset—a central desire to make it happen. We all were stubborn enough or dumb enough or persistent enough or unwilling to say we failed, but none of us would quit until the job was done.

The University of Louisville Medical School traces its long history back to 1839. At one time, we were training the second largest number of medical students in the country, surpassed only by New York City. Five medical institutions were consolidated into one in 1908. One of them had been the Louisville Medical College, which commissioned our 1893 structure.

The primary building has four stories with a rustic limestone exterior. Its roof line features a variation of towers and gables. The building itself is punctuated by fine carved stone sculptures throughout its exterior. There are over 400 windows with flat, rusticated, limestone lintels in this building.

The main entrance features a large, round arch surrounded by low columns; there is a projecting square tower which at one time contained a bell and a clock. Actually the clock tower at the southeast corner of this structure is the focal point of the building. The red tile roof, a loggia and pinnades, and a pair of narrow, rounded-arch windows all contribute to the vertical mass of the tower.

To the rear is a four-story, yellow brick building which was built in 1937 by the WPA. It is a very simple but firmly built structure. There was a narrow red brick building to the west of the original building, which had been used many years as a sanatorium. This



The old apothecary, immediately to the north of the old Medical School property, is now the main entrance of Louisville's Ronald McDonald House.



This famous main entrance at 101 W Chestnut St became the symbol of the U of L Medical School's Sesquicentennial celebration in 1987.

building had no historical significance and was razed at the beginning of our project to provide functional space for parking.

When we started the project, we thought we would simply raise funds, restore the building, and rent some of the restored space to the Jefferson County Medical Society and other interested community agencies for a very low and reasonable rent. We thought this whole process could be done over several years. There was no question before we began the process that we would succeed. There were people interested in raising money. However, on occasion we found there were more people interested in raising money than giving money. We also found there were many people interested in space, but not interested in paying rent for the space.

We received a lot of encouragement and some money from the Kentucky Heritage Commission. We found that encouragement was important to keep the project moving.

We began the study with a feasibility report. Everything looked doable. We felt we would be able to rent space for $6.50 to $7 per square foot. However, it would be necessary to raise a significant amount of up-front capital to make the project successful.

The charitable Medical Foundation of the Jefferson County Medical Society, which is a 501C-3 nonprofit corporation, took on the project, and then a Steering Committee was appointed on which a number of us served for about eight years.

The first year the Steering Committee operated was in 1977–78. Some 60 meetings were held in that one year at seven o'clock in the morning. We worked with architects as well as fundraisers. During that year we raised $315,000 from physician pledges.

The Steering Committee was firmly committed to this project and from the Steering Committee members, about 10 people in all, $75,000 was raised. Happily the balance sheet of the Medical Foundation contained $58,000 when we started the project. This money helped set up the project, get our initial architect plans drawn, and finance our initial fund raising effort.

By 1978–79, we had raised approximately $1 million. Over $458,000 had been contributed by approximately 60% of the Medical Society membership, including physicians' pledges from 35 states. We received a grant of $167,500 from the Kentucky Heritage Commission. At this point the project became a massive balancing act.

We had to get things going and had to show people who were now pledging money that we were able to move ahead. Unfortunately, inflation was zooming at a tremendous rate, and we were having problems collecting money. The federal government stopped funding heritage grants. Soon our fellow physicians began to say, "We told you it couldn't be done. You guys are into this over your heads." We all realized that, but we decided to get some periscopes and get at least some air down to where we were. We had to move the project ahead.

Fortunately at this point, some superb community foundations began to give us additional money. It became obvious that there was no way to raise enough money to get the entire project done through one master contract. It was now nearly 1980 and we were in the third year of our project. We were making plans and changing directions, but the final goal was to try to get the project completed. Above all, we decided that we were not going to borrow money to obligate the Medical Society or Foundation to long-term debt. This project had to take place on a pay-as-you-go basis.

We had completed the outside restoration of the building including a new roof and replacement of 400 windows with insulated double-pane windows. Over $10,000 was spent to remove debris, laboratory tables, and all the other 90-year accumulation of dilapidated equipment that the medical school abandoned.

Now we had completed our first two phases. One, we had cleaned the outside of the building to let people know that we were really doing something, and we had completed Phase II which was replacing all the windows, doors, and roof.

Nothing yet had been done to the interior and we knew if we were to keep the project moving, we had to have some live activity occurring inside. Too many people were saying we had done a wonderful job with the outside of the building; who were we going to sell the building to so they could finish the inside? We weren't going to sell it to anybody. We were determined to get it completed for the Medical Society, Medical Foundation, and the community.



Workers cleaning and renovating the ornamental iron stairway and brass handrail found metric bolts indicating the units may have been imported.

The Steering Committee continued to meet for a regular, weekly 7 AM breakfast, and on April 18, 1980, decided to begin Phase III of the project.

Phase III was to renovate the first floor, install a sprinkler system to protect the halls and stairways, and get a heating and air-conditioning system working on the first floor of the building. A central electrical control system was installed which could supply the first floor and could be expanded later to the rest of the building. We had only enough money to make this happen. It would cost almost $500,000 to get ready to move into the building.

Fortunately a large trust grant had just arrived. We went to our contractor, the Al J. Schneider Associates, who had completed the previous phases and told them that we had to get into the building. The amount of money we could spend was limited to just under



Dramatic colors and lighting accent the original mosaic tile flooring in the Community Health Building's main first floor corridor.



Creative renovation work resulted in a warm, home-like atmosphere appropriate for visiting out-of-town parents of children receiving treatment in Louisville area hospitals.

$500,000. In order to keep this project alive we had to be moved into the building in the early part of 1981. Ferd Effinger, president of our construction company, called one week later and said he was prepared to start the project on our terms. I told him we had no money for overrun. He said that would be no problem.

It was March 17, 1981, St. Patrick's Day. Maybe the luck of the Irish was with us because the first floor of our building was totally completed and our overruns on restoring a major historic building had been less than two-tenths of 1%.

The building was no longer being called the Old Medical School Building but now had been renamed The Community Health Building. On the first floor of this building, we were providing offices for the Jefferson County Medical Society and renting space to the American Diabetes Association, Hospice of Louisville, and the Kidney Foundation.

Fortunately for all of us, the Visiting Nurse Association needed space, and we were dealing with a superb, cooperative board with outstanding leadership. We were able to work out a 10-year lease arrangement. And another large grant was obtained to help restore the third floor.

It was a problem running a building with the first and third floors in operation and the second floor not at all completed. However, physicians continued contributing money, grants continued coming in, and people suddenly began to realize that this project was for real. In July 1982, the second floor of the building was completed. It now houses the "Health Education Center." A medical museum was developed on this floor along with a large auditorium. The facilities of the second floor are used by all the agencies that rent

from the building and many people in the community who find the auditorium a fine place for medical meetings, receptions, and weddings.

Three floors were now completed. On the second and third floors of the building, a separate furnace was installed which handled these two floors. We were finding that our heating and air-conditioning systems were working very well and very efficiently. We put a timer system onto our heating controls for all three floors and our energy costs were well within manageable limits.

The annex in the back of the main building had been built by WPA crews in 1937, featuring a beautiful limestone facade. The first two floors of the annex and part of the basement were rented to the Ronald McDonald House. We leased this space to them for 50 years. The Ronald McDonald House development group was community people interested in developing a place where the parent(s) of children could stay while visiting their children at nearby Kosair Children's Hospital. This phase of the development went very well. Over $1 million was raised by the Ronald McDonald group. They raised the resources in cash, in equipment and labor, and support came from many laborers and industry. In 1984, the Ronald McDonald House opened in the annex of our old Medical School building.

We thought we had the fourth floor of our building rented for a kidney dialysis unit but the project fell through because of hospital ownership changes within our community. A year later we rented space to Citicare (a Medicaid provider) on a five-year lease basis. Citicare's status changed however. They lost the State support and we lost our lessee. We were not totally idle when Citicare rented the fourth floor. They did get the fourth floor debris cleaned out and that saved us $10,000. And they paid a settlement of $31,000 on their lease. So, we were moving ahead on the fourth floor but certainly very slowly.

By 1986, the Visiting Nurse Association was running out of space. We still had not rented the fourth floor. But this group's innovative board and our willingness to work together enabled us to develop a plan to rent the fourth floor. We were able to acquire a large grant to help renovate part of the space, and in June of 1987, the fourth floor was completed and the Visiting Nurse Association moved in. They have a beautiful, open, 6,000 foot central room, with a large skylight, which formerly housed the old anatomy lab. They have handsome offices in the tower and additional offices in the front part of the building overlooking Chestnut Street.

A project that began as a dream late in 1976 really began firmly moving ahead in 1977 when a number of us were asked if we were willing "to work on a project that would take a year or a year-and-a-half." In 1987 we completed the task begun almost ten years ago.

The total cost of renovating the Community Health Building and the Ronald McDonald Annex, including the two projects, was $3,474,151. The total number of feet renovated in this project is noted below:

35,445 feet—Five floors including the basement in the Community Health Building
22,500 feet—Two floors and the basement in the Annex Ronald McDonald Building
15,000 feet—partial renovation of the 3rd and 4th floors in the Annex Ronald McDonald Building
72,945 feet of total renovation

$3,474,151 (the total dollars spent on this renovation project) divided by 72,945 renovated feet equals $47.63 (the cost per square foot of renovation).

Physicians gave $902,576, and through community support and local foundations we received $545,985. One large foundation, the James Graham Brown Foundation, has given a total of $720,000 in separate grants to our project and tenants.

At this time, all the space that has been renovated in the building is rented. The cash flow of the building is adequate to take care of rent and upkeep for the building. We do not owe the bank any money, and the project has been exceedingly successful.

Our Medical Foundation and Society have meetings on a regular basis in this building, and it has been a very important restoration project in our community. Many of our local health agencies meet in the building, and many anniversary parties, weddings, and dances have occurred in our second floor auditorium meeting space area.

All of us who have been involved in this project have learned a great deal. We learned to respect the frustration of builders. We learned to respect inflation. We learned to get along with one another at 7 o'clock in the morning—many, many times.

Above all, we learned that with true dedication and a desire to finish a project that we felt would be important for our community and for our medical profession, we could succeed if we were stubborn enough and determined enough to persevere. We were just that, and today we have a new jewel in Louisville.

The Board of Trustees of the Medical Foundation of the Jefferson County Medical Society was instrumental in making this project a reality. During the early years it encompassed the entire Board of Governors of the Jefferson County Medical Society, and for the first four years a special Steering Committee was appointed to help shepherd the Old Medical School Restoration Project. Medical Foundation Trustees who served on the Renovation Steering Committee were:

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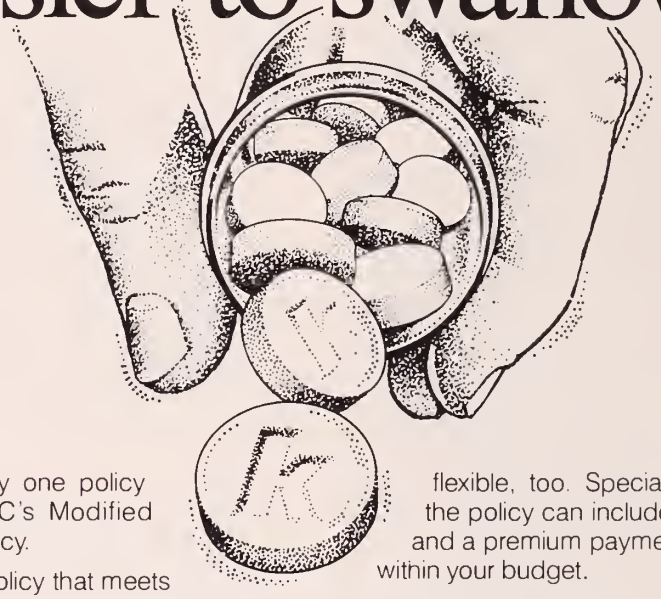
After 1982, the entire Board of Trustees of the Medical Foundation continued the project through its completion. In addition to the above Steering Committee members, the following Trustees of the Medical Foundation of JCMS provided leadership and sustained support throughout the 10-year effort:

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Acknowledgement

We wish to express our appreciation to Lelan K. Woodmansee, Executive Director of the Jefferson County Medical Society, for his assistance in reviewing this article.

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Living With Lung Cancer

Triad Publishing Company
1110 NW 8th Avenue, Suite C
Gainesville, Fl 32601
Barbara G. Cox, David T. Carr, MD,
Robert E. Lee, MD
$7.95

Funded in the National Cancer Institute, the workings of this book are to bring a practical side to the emotional turmoil facing the cancer patient and his family. This second edition is updated with recent treatments, medications, referral sources and support group information up to the publication date of 11/16/87.

Dr Carr is a seasoned specialist in the treatment of lung cancer. Ms Barbara Cox, a medical writer, was enlisted for her expertise in medical education. They worked with Dr Lee, whose work involved treatment of lung cancer and thus he was positioned to know the medical armamentarium. Their collaboration through a series of interviews with patients, current practices, and on-the-line experience with lung cancer consummated in this primer. Reviewed by patients, physicians, and lay people familiar with communication skills, this book is streamlined, readable, palatable and very informative.

Early chapters go over the basics of lung anatomy and function, the vulnerable areas, origin of cancer and pathogenesis of attack. Illustrations are included, well drawn and crisp, and I am sure helpful. Diagnosis is discussed with emphasis on the new methods of detection and some kindly words of encouragement for those who are frightened by the hardware.

Treatment is the heart of the book. First surgery, the classic approach, is detailed with discussion of decision to operate, what can be done, post-operative problems and physical and cosmetic results. Shorter than the succeeding chapters on radiotherapy and chemotherapy, the surgery chapter probably suffered from the bias of the authors.

Radiotherapy on the other hand is given lengthy discourse. Reasons for choosing X-ray are debated, with pros and cons. What actually will take place graphically comes to life with pictures, details, side effects and long-term problems detailed.

Chemotherapy is also well covered with a large chapter on decision making, types of drugs, administration method, side effects and coping with results. Obviously patients have great interest in this part because of their more intimate involvement in the actual enactment of their therapy.

Nutritional information is very critical for the cancer patient. Hospitals start this learning process, but of necessity the home environment must be supportive to the extent of attention to eating sufficient and vital food.

Some time is spent on developing coping mechanisms. For the patient, family, and the physicians caring for the lung cancer patient, these words are very germane.

Actually, most cancer patients would be helped by reading this book, but the lung cancer patient in particular will be very enlightened. This is not a sensational piece that rivets your attention, but rather a comfortable book that puts an arm around the reader with warm support.

Stephen Z. Smith, MD

Continuing Medical Education

1988

FEBRUARY

10–13 Sports Medicine — For ALL Practitioners, La Posada Resort, Scottsdale, Arizona. Contact: Stuart C. Zeman, MD, Course Chairman, 2999 Regent St #203, Berkeley, California 94705, (415) 540-8686.

21–26 Nineteenth Family Medicine Review — Session I, University of Kentucky, Lexington, Kentucky. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

27 Kentucky Society of Medical Assistants, Educational Seminar, Assertiveness Training, Springs Hotel, 2020 Harrodsburg Road, Lexington, KY. Contact: Doris B. Balasa, CMA, 2533 Frank Street, Villa Hills, KY 41017, (606) 341-0228.

February–April

The Johns Hopkins University School of Medicine 29th Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. Home Study Course A is provided each registrant for personal reading and microscopic study at their own laboratory in preparation for Course B. Contact: John K. Frost, MD, 604 Pathology Building, The Johns Hopkins Hospital, Baltimore MD 21205.

MARCH

3 "Current Treatments of Hyperlipidemia" — offered in two sessions, morning and evening, Lexington KY. 4 CEUs, cost $25. Teaches normal and abnormal lipid metabolism and current treatment modalities used in the care of a patient with hyperlipidemia. Contact: Paula Gentry, 120 N Eagle Creek Dr, #321, Lexington, KY 40509, (606) 263-5032.

APRIL

15–16 First Annual Markey Cancer Center Symposium: Biologic Response Modifiers, Lexington, KY. For physicians and nurses. Contact: Hilary Wood, RN, MSN, (606) 257-4500.

25–May 6 The Johns Hopkins University School of Medicine 29th Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. In-Residence Course B is extremely concentrated lecture series with intensive laboratory studies and vital clinical experience at the Johns Hopkins Medical Institutions, Baltimore MD. Contact: John K. Frost, MD, 604 Pathology Building, The Johns Hopkins Hospital, Baltimore, MD 21205.

MAY

9–13 "Diabetes In-Depth Training Workshop," Lexington, KY. 39 CEUs, $350 (daily rates also available). One week training program in diabetes, effective patient teaching, and setting up a diabetes program. Contact: Paula Gentry, 120 N Eagle Creek Dr, #321, Lexington, KY, (606) 263-5032.

JUNE

16–18 The 33rd Annual Great Smoky Mountain Pediatric Seminar at the Park Vista Hotel, Gatlinburg, TN. Sponsored by University of Tennessee Medical Center at Knoxville, College of Medicine, Department of Pediatrics and Knoxville Area Pediatric Society. Contact: Dr. Sandra Loucks, University of Tennessee Medical Center, Dept. of Pediatrics, 1924 Alcoa Hwy., Knoxville, TN 37920; (615) 544-9331.

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All advertisements must be approved by the Board of Editors. Deadline is the first of the month two months preceding the month of publication. Charges for advertising are: 20¢ per word. Average word count: 7 words per line. $5.00 minimum. Send payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205.

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Pamela H. Potter

Highlight on Adolescent Health Projects

In her inaugural address, AMA Auxiliary President, Mrs. Edward Szewczyk, urged county auxiliaries to support the AMA's Initiative on Adolescent Health through their county health projects. For many years, county auxiliaries across Kentucky have offered a variety of excellent adolescent health projects. AKMA is pleased to have the opportunity to share with you information about three of these projects.

Teen Symposium

In October, the Fayette County Medical Auxiliary sponsored its second annual Teen Symposium. The 1986 Symposium addressed the issues of teen suicide, substance abuse, and peer pressure. The program this year focused on teen pregnancy. The daylong workshop featured a national expert and panels of local professionals and teens. More than 200 parents, educators, counselors, clergy, and health professionals from the community attended this very informative program. Many program participants have asked the Auxiliary to continue the Symposium in future years.

Layette Program

The Auxiliary to the Campbell-Kenton Medical Society addresses the problems associated with teenage pregnancy through its ongoing Layette Program. Recognizing that Kentucky has the highest teenage pregnancy rate in the nation and that teens often lack information regarding prenatal care and parenting skills, the Auxiliary initiated the Layette Program to motivate obstetrical patients to attend educational programs on these topics offered by local health professionals. The Auxiliary supplies layettes that are raffled each month in three prenatal clinics in Boone, Campbell, and Kenton counties. The patients are allowed to enter the raffle each time they attend an educational program offered by the clinic. The numerous entries in each monthly raffle provide evidence of the success of this special incentive program.

Substance Abuse

With funding provided by the Daviess County Medical Society, the Daviess County Medical Auxiliary printed and distributed more than 5,800 pamphlets entitled "Parties and Teens — A Practical Guide for Parents" to the parents of teenagers in the Owensboro-Daviess County area. The pamphlet offers parents practical guidelines to follow in eliminating alcohol and drug use and abuse at parties given or attended by their teenage children. The Auxiliary publicized the pamphlet through a program presented one evening at a local high school. The program featured a panel composed of a physician, judge, counselor, teacher, parent, and two teenagers who provided information dealing with the medical, legal, social and emotional aspects of substance abuse.

The three adolescent health projects highlighted above provide only a sample of the many outstanding projects sponsored or supported by the county auxiliaries in Kentucky. We look forward to telling you about other auxiliary projects in future issues of the *Journal*.

Pamela H. Potter
AKMA President

"High Quadriplegia– The Ultimate Challenge"

Plan to attend:

A two-day symposium at Colony Square Atlanta

April 7-8, 1988

Registration: $225

Symposium
Co-Chairmen

David F. Apple, Jr., M.D.
Medical Director

Donald P. Leslie, M.D.
Medical Director
High Quadriplegia Program

A medical symposium addressing the acute and rehabilitative care of the C-1 through C-4 high quadriplegic. Hosted by Shepherd Spinal Center in Atlanta, now the nation's largest dedicated spinal cord injury hospital. Issues to be investigated include: medical, psychosocial and high tech approaches to care and rehabilitation. Special emphasis on ventilator weaning, the interdisciplinary care approach, phrenic nerve pacer implants and community reintegration.

Symposium Preview:

High Quadriplegics: They Can Go Home Again

With high quadriplegics surviving at unprecedented rates, quality of life issues and discharge planning are of paramount importance from the first day of admission to the specialty setting. The philosophy of treatment at SSC will be covered, including the referring physician's role in long-term medical management.

Medical Overview: Care of the High Quadriplegic

The potential for complications such as deep vein thrombosis, stress ulceration, decubitus, pneumonia, urinary tract infections and sepsis poses a serious threat to high quadriplegic patients. Prevention strategies, the benefits of early mobilization of ventilator dependent patients and medical management of complications are covered.

Ventilator Weaning

All high quadriplegics at Shepherd Spinal Center are evaluated to determine their candidacy for phrenic nerve pacer implants and their potential for weaning from mechanical ventilation. The pulmonary evaluation studies performed at SSC and protocols for weaning are included.

Panel and Concurrent Session Topics:

- Pulmonary Issues
- Social Work: Discharge Planning, Peer Support, Sexuality
- The Therapeutic Value of Sensory Experience
- The Biofeedback Program at SSC
- Ventilator Home Care
- Focus On: Phrenic Pacer Implantation
- Departmental Presentations by O.T., P.T., Recreation Therapy, Social Work, Respiratory Care, Education, Nutritionists
- Emphasis on specialized equipment

For Physicians Only:

Grand Rounds at Shepherd Spinal Center

REGISTRATION IS LIMITED. Reserve your space today, by sending a check for $225, payable to Shepherd Spinal Center, to: Lesley M. Hudson, Symposium Registrar, Shepherd Spinal Center, 2020 Peachtree Road, N.W., Atlanta, GA 30309. Confirmations of early registrations and a symposium information packet will be mailed in October.

High Quadriplegia– The Ultimate Challenge

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Check one: ☐ Check enclosed. Reserve my space now. ☐ Please send a complete information packet.

Case Study: Larry McAfee Diagnosis: C-1 Complete Prognosis: Promising

Contact the Admissions Office for routine information. A physician is on 24-hour call to assist in emergency arrangements.

When 28 year-old Larry McAfee was brought to Shepherd Spinal Center as a result of a motorcycle accident in late 1985, he was classified as a C-1 complete spinal cord injury. He was suffering from severe burns on his right ankle, massive atelectasis, pneumothorax and pneumonia. Paralyzed instantly at the first cervical vertebrae below the brain stem, he required mechanical ventilation for breathing.



The road to a meaningful quality of life has been a long one for Larry, requiring intensive medical care, rehabilitation, counseling–and Larry's own unsinkable spirit.

We couldn't promise Larry miracles, but we could promise him the care of the largest rehabilitation hospital in the nation specializing in paralyzing spinal cord disorders, Shepherd Spinal Center in Atlanta. With the help of various adaptive devices and skilled attendants, it is possible for Larry to live independently in an apartment since his discharge from Shepherd. He now actively pursues his goal of a career as a computer programming consultant.

At Shepherd Spinal Center, our ultimate challenge is to assist patients like Larry in a comprehensive High Quadriplegia Program, (C 1-4). We involve referring physicians in all aspects of discharge planning for follow-up medical supervision with the hope that patients like Larry will go home again.

Your patients count on you. Accept the challenge and work with us...for them.

The Georgia Regional Spinal Cord Injury Center/Fully Accredited by CARF and JCAH/Designated "Model Spinal Cord Injury Program" by U.S. Dept. of Ed./Now offering a comprehensive Spina Bifida Program/Nation's Largest Dedicated Spinal Cord Injury and Disease Treatment Facility.

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Health and Safety Tip From the American Medical Association

MARKERS LISTED TO IDENTIFY ALCOHOLICS

How can you tell that a regular, heavy drinker has crossed over the line and become an alcoholic, who no longer can control his or her drinking?

The American Medical Association in its Manual on Alcoholism points to some markers to help identify the alcoholic.

1. Increasing consumption of alcohol, with frequent, perhaps unintended, episodes of intoxication.

2. Drinking to handle problems or relieve symptoms.

3. Obvious preoccupation with alcohol and the frequent need to have a drink.

4. Surreptitious drinking or gulping of drinks.

5. Tendency toward making alibis and weak excuses for drinking.

6. Refusal to concede what is obviously excessive consumption and expressing annoyance when the subject is mentioned.

7. Frequent absenteeism from the job, especially following weekends and holidays.

8. Repeated changes in jobs, particularly if to successively lower levels, or employment in a capacity beneath ability, education and background.

9. Shabby appearance, poor hygiene, and behavior and social adjustment inconsistent with previous levels or expectations.

10. Persistent vague physical complaints without apparent cause, particularly insomnia, stomach upsets, headaches, loss of appetite.

11. Multiple contacts with the health care system with disorders that are alcohol caused or related.

12. Persistent marital and family problems, perhaps with multiple marriages.

13. History of arrests for drunkenness or drunken driving.

Submitted by the KMA Impaired Physicians' Committee



Most patients need only one.

K-DUR™ 20 Microburst Release System™
(potassium chloride) 20 mEq Sustained Release Tablets

A daily prophylactic dose in a single tablet.

Please see next page for brief summary of prescribing information.

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K-DUR™ Microburst Release System™

(potassium chloride) Sustained Release Tablets

INDICATIONS AND USAGE: BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-OUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-OUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINOICATIDNS, WARNINGS,** and **OVERDDSAGE).** There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS);** other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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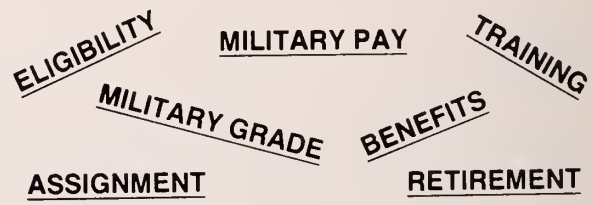


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1987 Actions of the KMA Judicial Council



The following is a summary of actions taken by the Judicial Council of the Kentucky Medical Association during 1987. This summary is provided in response to Resolution T, adopted by the 1986 House of Delegates, which called for the Council to work with the Board of Medical Licensure in promoting quality medical care and informing the membership of these efforts on a periodic basis.

Several complaints were considered by the Council, and in some cases it was determined that insufficient grounds existed for complaint, and these matters were dismissed. It should be noted that the Judicial Council does not have subpoena powers, and must rely on the parties involved to provide adequate information for a full consideration of an issue.

A complaint was received from the director of a drug treatment center indicating that a patient had named a Kentucky physician as a drug source. The Board of Medical Licensure was informed of this matter and conducted a preliminary investigation. However, the patient wished to remain anonymous, no specific drugs were named, and no time frame was given. Based on the information available, the investigator found no unethical behavior, but it should be pointed out that no comprehensive investigation can be conducted by the Council or the Licensure Board based on such limited information.

The Council was asked to review a matter originally considered by the Board of Medical Licensure involving a grievance filed against a physician. The Licensure Board had entered an Agreed Order with this physician, and this action was being questioned. The Council reviewed a great deal of information regarding these complaints. However, it was determined that the physician was not a member of the Association, and the Council therefore expressed its concerns regarding this matter to the Board of Medical Licensure for additional consideration. The Board did not feel it would be appropriate to reopen the old file, but did agree to review new information discovered by the Council during its investigation.

The Council was asked to determine the appropriateness of a newsletter distributed by a physician. After examining the format of the newsletter and the nature of the information being conveyed to patients, the Council did not feel its distribution was unethical.

A KMA member expressed concern to the Judicial Council that a physician was working at a clinic in Kentucky while charges were pending against him with the Virginia Board of Medical Licensure. This

matter was referred to the Kentucky Board of Medical Licensure for appropriate action.

The Judicial Council heard, on appeal from the Jefferson County Medical Society, a complaint regarding an autopsy. The family member of the deceased questioned the treatment his aunt had received, and it was his contention that the autopsy procedure was not adequately explained to him. He maintained that he had signed the permission form while still in a state of shock.

During discussion of his aunt's hospitalization and death, it was determined that these concerns were primarily due to a lack of communication. The Council was able to allay most of these concerns by explaining the course of treatment the patient had received, and by explaining that autopsies are peformed to determine the exact cause of death and to broaden medical knowledge for future application.

The Council reviewed a complaint concerning a physician's comments to a nursing home patient regarding religious beliefs. Through the intercession of the local Trustee, this matter was resolved, and the Council cautions physicians not to attempt to impose personal religious beliefs on their patients.

A complaint was made by a nurse anesthetist, formerly employed by a hospital-based physician, claiming that this doctor had blocked his employment elsewhere. In addition, he complained about the physician's operation and billing practices. The Council was informed that a suit might be pending in this matter and requested additional information from the complainant. This was not forthcoming, and based on available information, the Council found no unethical behavior on part of the physician.

A complaint was received from a man who claimed that his father had been inappropriately treated for chronic anxiety. The patient eventually committed suicide. After reviewing the records and a report from the area Trustee, the Council determined that: (1) the physician was qualified to diagnose and treat anxiety and depression, and these conditions often present simultaneously; (2) the medication was appropriate; (3) the dosage was not inappropriate; (4) according to the medical records, the patient had been asked to return in six months for a follow-up visit, and the patient and the family had some responsibility to see that this appointment was kept; and (5) the medication was not administered for an inappropriate length of time.

Opinions

Physician Responsibility Under Cost Containment Plans

The Board of Trustees referred to the Judicial Council a request from the KMA Trends Committee for an opinion regarding the physician's responsibility and legal obligation to resist administrative pressures to reduce or avoid rendering care under alternative delivery systems.

The Council approved an opinion developed by Legal Counsel and submitted it to the Board of Trustees with a recommendation that it be printed in the *KMA Journal*.

Dispensing of Drugs from a Physician's Office

The Judicial Council was asked to render an opinion on the dispensing of drugs from a physician's office.

It was the opinion of the Council that dispensing drugs through the physician's office was a traditional practice and was not unethical as long as there was no exploitation of patients.

Physicians Treating Immediate Family Members

The Judicial Council was asked to render an opinion regarding the appropriateness of physicians treating themselves or members of their immediate family.

It was the opinion of the Council that, except in emergency situations, physicians should not attempt to treat themselves or members of their immediate family for a serious illness or injury, as the physician's emotional involvement may affect objectivity and impair medical judgment.



"Planning for Retirement" Workshop Set for March 9 in Louisville

The Kentucky Medical Association will sponsor "Planning for Retirement," a one-day workshop for KMA members and their spouses, on Wednesday, March 9, from 9 AM to 5 PM, at the Hyatt Regency Hotel in Louisville.

Designed for physicians nearing retirement or those wishing to plan ahead for normal retirement, premature death or disability, the workshop will answer questions such as, "How can I sell my practice?," "What must I do with my patient's medical records?," and "How can I reduce anxieties about this transition?"

Faculty for the workshop will consist of an attorney specializing in tax law, a financial planner, and a management consultant from Conomikes Associates.

Since enrollment in the workshop is limited, contact the KMA Office as soon as possible for further information on registration.

. . .For Those "Starting A Practice"

KMA's 7th "How to Get Started in Practice" Workshop will be held Thursday and Friday, March 10–11, at the KMA Headquarters Office in Louisville.

Although the workshop is primarily aimed at physicians who will be completing their residency training in the next year or two, physicians changing practice settings or wanting to know more about the business side of a practice have benefited from previous workshops.

Registration for the workshop, which is limited to 30 physicians, can be made by contacting the KMA Office.

Updates

Doctor Shields Selected as President of Neurological Group

Christopher B. Shields, MD, Louisville, was selected as President of the Congress of Neurological Surgeons at the organization's recent annual meeting in Baltimore. Doctor Shields is Professor of Surgery (Neurosurgery) at the University of Louisville.

A graduate of the University of Toronto, Doctor Shields received his neurosurgical training at the Winnepeg General Hospital, and took postgraduate study in microvascular neurosurgery at the University of Vermont. He is currently affiliated with Norton Hospital, Kosair-Children's Hospital, Humana Hospital University, and the Veterans Administration Medical Center in Louisville.

The Congress of Neurological Surgeons is a major neurosurgical organization focusing on the needs of younger neurological surgeons.

18th Annual Emergency Medical Care Seminar

The 18th Annual Emergency Medical Care Seminar will be held on June 7, 8, and 9 at the Executive West Motor Hotel in Louisville.

Themes include "Pediatric Emergencies" and "Medical Neurologic Emergencies." Invited speakers include William DeVries, MD, whose topic will be "Pre Op Stabilization of Aortic Aneurism" and Frank Lavoie, MD, who will speak on "Dealing with Violent and Abusive Patients."

KMA Physician Placement Service

Physician placement is another service offered by the Kentucky Medical Association. The Association acts as a clearinghouse by providing assistance to physicians seeking practice opportunities in Kentucky and to anyone who is searching for a physician.

A booklet entitled "Practice Opportunities in Kentucky" is published in January and July. We combined our services with those offered by the Kentucky Physician Placement Service, Cabinet for Human Resources, Frankfort, Kentucky. As a result, there is a substantial increase in the number of opportunities listed. If you have just completed your medical training or are interested in a change of location, you will find this booklet helpful.

Kentucky Medical Association also publishes a "Physician Seeking" list which briefly outlines the background of the physician. This list is disseminated to communities, hospitals, clinics and physicians who are seeking the services of a physician.

If you are interested in these KMA services, please contact the Physician Placement Office, 3532 Ephraim McDowell Drive, Louisville, Kentucky 40205; telephone: 502-459-9790.

Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl [brand of cimetidine hydrochloride] injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline [Theo-Dur®, Key Pharmaceuticals, Inc.], demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. [Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.]

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states [e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation], predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients [approximately 1 per 100,000 patients], including agranulocytosis [approximately 3 per million patients], have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia [approximately 3 per million patients] and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 [intended for institutional use only); 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 [intended for institutional use only), and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 [intended for institutional use only).

Liquid: 300 mg./5 ml., in 8 fl. oz. [237 ml.] amber glass bottles and in single-dose units [300 mg./5 ml.], in packages of 10 [intended for institutional use only).

Injection:

Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl [brand of cimetidine hydrochloride] injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

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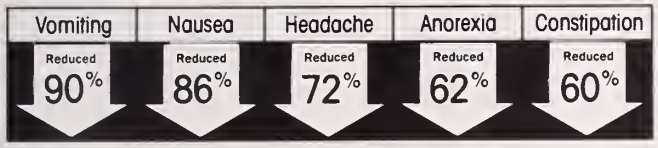
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J-6138 January 1986

See the improvement in the first week[1]

- **Sleep improvement in 74% of patients after first h.s. dose[2]**
- **Significantly faster relief–62% of total four-week improvement evident in first week versus 44% with amitriptyline alone[1]**
- **Dramatic first-week reduction in somatic complaints[2]**

% Reduction in Somatic Symptoms[2]



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Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.



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References: 1. Feighner JP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979 **2.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

Limbitrol® (IV)
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Indications: Relief of moderate to severe depression associated with moderate to severe anxiety
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants. Do not use with monoamine oxidase (MAO) inhibitors or within 14 days following discontinuation of MAO inhibitors since hyperpyretic crises, severe convulsions and deaths have occurred with concomitant use; then initiate cautiously, gradually increasing dosage until optimal response is achieved. Contraindicated during acute recovery phase following myocardial infarction.
Warnings: Use with great care in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur in patients taking tricyclic antidepressants and anticholinergic-type drugs. Closely supervise cardiovascular patients (Arrhythmias, sinus tachycardia and prolongation of conduction time reported with use of tricyclic antidepressants, especially high doses. Myocardial infarction and stroke reported with use of this class of drugs.) Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

Since physical and psychological dependence to chlordiazepoxide have been reported rarely, use caution in administering Limbitrol to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms following discontinuation of either component alone have been reported (nausea, headache and malaise for amitriptyline; symptoms [including convulsions] similar to those of barbiturate withdrawal for chlordiazepoxide).
Precautions: Use with caution in patients with a history of seizures, in hyperthyroid patients or those on thyroid medication, and in patients with impaired renal or hepatic function. Because of the possibility of suicide in depressed patients, do not permit easy access to large quantities in these patients. Periodic liver function tests and blood counts are recommended during prolonged treatment. Amitriptyline component may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady state concentrations of the tricyclic drugs. Concomitant use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Limbitrol should not be taken during the nursing period. Not recommended in children under 12. In the elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects.
Adverse Reactions: Most frequently reported are those associated with either component alone: drowsiness, dry mouth, constipation, blurred vision, dizziness and bloating. Less frequently occurring reactions include vivid dreams, impotence, tremor, confusion and nasal congestion. Many depressive symptoms including anorexia, fatigue, weakness, restlessness and lethargy have been reported as side effects of both Limbitrol and amitriptyline. Granulocytopenia, jaundice and hepatic dysfunction have been observed rarely.
The following list includes adverse reactions not reported with Limbitrol but requiring consideration because they have been reported with one or both components or closely related drugs:
Cardiovascular: Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke.
Psychiatric: Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania and increased or decreased libido.
Neurologic: Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns.
Anticholinergic: Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract.
Allergic: Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus.
Hematologic: Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia.
Gastrointestinal: Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue.
Endocrine: Testicular swelling and gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion.
Other: Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Overdosage: Immediately hospitalize patient suspected of having taken an overdose. Treatment is symptomatic and supportive. IV administration of 1 to 3 mg physostigmine salicylate has been reported to reverse the symptoms of amitriptyline poisoning. See complete product information for manifestations and treatment.
Dosage: Individualize according to symptom severity and patient response. Reduce to smallest effective dosage when satisfactory response is obtained. Larger portion of daily dose may be taken at bedtime. Single h.s. dose may suffice for some patients. Lower dosages are recommended for the elderly. Limbitrol DS (double strength) Tablets, initial dosage of three or four tablets daily in divided doses, increased up to six tablets or decreased to two tablets daily as required. Limbitrol Tablets, initial dosage of three or four tablets daily in divided doses, for patients who do not tolerate higher doses.
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Page 113

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Volume 86, Number 3 March 1988

SCIENTIFIC

Pyogenic Sacroiliitis - A Case Report
David T. Tao, MD 121

Percutaneous Balloon Aortic Valvuloplasty
G. S. Sohi, MD; Humberto Coto, MD; Abraham Joseph, MD 124

Recurrent Sulfonylurea Induced Nocturnal Hypoglycemia Managed with Tolbutamide
George C. Borst, III, MD 129

EDITORIAL

SZS 133

ASSOCIATION

Highlights of December KMA Board Meeting 146
Kentucky Physicians Attend AMA Interim Meeting 148
Awards Nomination Form 150
Updates 153

REGULAR FEATURES

President's Page 113
Auxiliary 139
Book Review 141
CME 154

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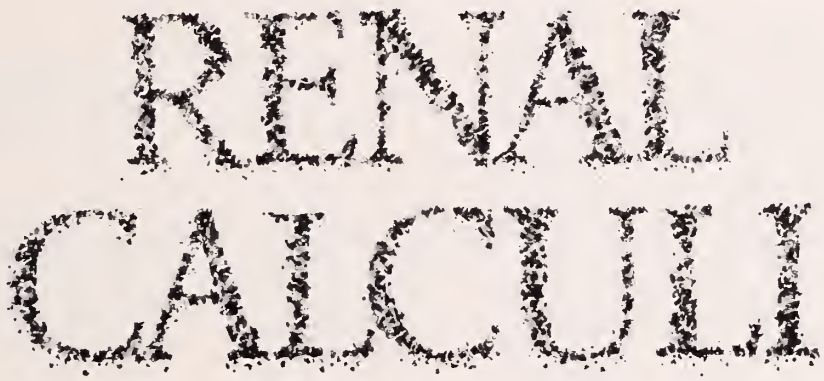
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Charleston Area Medical Center 111
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KMIC 152
KMIC Leasing Company 108
KMIC Investment Company 140
Kentucky Air National Guard 155
Lexington Clinic 120
Eli Lilly & Company 144
M.E.H. Affiliates, Inc 119
Marion Laboratories 142,143
Medical Protective Company 131
Palisades Pharmaceuticals 140
Roche Laboratories 157,158
P.I.E. Mutual Insurance Company 156
Paul Semonin Realtors 155
Smith, Kline & French 117
U.S. Air Force 145
U.S. Army 112

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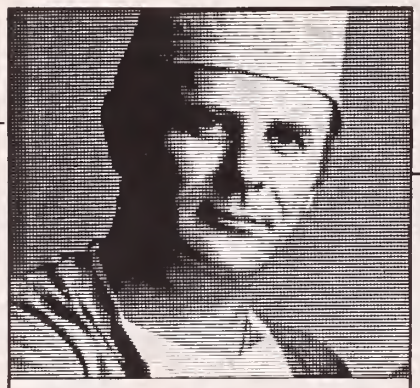
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-Building on the PLI Foundation-
-Welcome to the Kentucky General Assembly-

We have all heard stories about the National Football League and first-year players' baptism into the pros. Most of you remember the story about two 300-pound linemen clobbering a rookie running back, each grabbing a leg and saying, "Make a wish." Perhaps the most famous NFL line occurs when the greenhorn gets smashed for the first time by the all-pro linebacker who then intones the famous trademark, "Welcome to the NFL."

I suppose one's introduction to Kentucky-style politics and the General Assembly could be just as shocking. "Welcome to the Kentucky General Assembly," to the uninitiated, would be just as appropriate and as ominous.

Welcome, also, to Frankfort, which during the session has been humorously described as "Kentucky's largest theme park."

Bismarck stated that "A person with a taste for legislation or sausage should never watch the creation of either."

The late Illinois senator Edward Dirksen commented that "Politicians have three major goals—get elected; get reelected; don't get mad, get even."

Old-time Kentucky politicians always say that the General Assembly ought to meet two days every 60 years rather than 60 days every two years.

Bismarck, Dirksen, and other political pundits rip away the facade and glamour of politics and prepare one for the real world of gut politics.

If we can begin to understand the psyche of the politician, and the slowly grinding process of lawmaking bodies, then we can learn to tolerate and hopefully develop an interest in politics. An obstacle to understanding the political process is refusing to accept some basic political rules for survival.

1. ***Politics thrive on compromise—A half a loaf is better than no loaf at all.***
   I am not here today to recommend that we compromise everything we do, because that is not the way the game of life is played. However, political reality dictates that occasionally you compromise. . .or you walk away empty-handed. Sometimes we have no choice but to accept the hand the General Assembly deals. Therefore, we shouldn't fool ourselves and expect the 1988 Kentucky General Assembly to give us everything we want. We may be faced with hard choices. When the time comes the options will be weighed and our position will be developed with the best interests of all KMA's membership in mind. But, let me state clearly that issues relating to quality of patient care and freedom to practice have never been nor will they ever be negotiable.
2. ***Voting records determine future elections—What did you do for me today?***
   Getting elected is expensive. Politicians need your money, your time, your influence. After the 1986 Session, KMA printed and mailed to every physician the voting records of representatives and senators. Did you take the time to review their record? If it was good, did you contribute to their campaign? If the voting record was not good, did you talk to them? Talk to your representatives—let them know your position—then contact KMA and find out whether they supported your position. If not, remember the old Dirksen adage, "Don't get mad—get even!"
3. ***The loudest home folks—bring home the bacon.***
   The proverbial squeaky wheel gets

the grease. Organized, efficient letter writing, phone contacts, and person-to-person discussions bring about political results. Establish a personal relationship with your representative, not only during the session, but during the interim. These are political relationships that produce long-term results.

Since October 1986, the Professional Liability Insurance Campaign has centered its attention upon patients, members of the General Assembly, and physicians. Numerous articles have appeared in every Kentucky newspaper regarding the liability crisis and KMA's position. The three largest newspapers in the state have run at least one front-page spread. All three have editorially endorsed tort reform. We have worked very closely with members of the General Assembly, particularly with the Task Force on Liability Insurance which Dick Hench and Carl Wedekind served so ably. Four of five KMA proposals were adopted and included in the Task Force's final report. In politics, four out of five "ain't all bad."

We also intend to introduce separate legislation to reduce the statute of limitations for minors. We will do everything in our power to obtain passage of this legislation despite the 25 to two vote against this measure by the Task Force. Bear in mind that in 1986 the Senate Banking and Insurance Committee refused to post our bill for a hearing until this portion was deleted.

Our task will not be easy. Trial lawyers are formidable opponents and crafty politicians, who will do everything within their power to defeat tort reform. We shouldn't kid ourselves. If we thought optometrists and chiropractors were tough, we haven't seen anything yet. An added dimension is the fact that while two physicians serve in the legislature, 32 lawyers, which constitute 24% of the KGA membership, will be voting on our PLI measures.

Despite all of KMA's PR activities over the past year and a half, I sense an increasing lack of concern with the liability problem among many physicians. Apparently some have accepted the higher Med-Mal rates as a fact of life, and have incorporated the cost into the budget. That is the exact line our opponents used in 1986—"Malpractice insurance is the cost of doing business." But don't be misled; the crisis may be abating in some areas, but it continues to grow in the medical community.

I realize that I'm preaching to the choir. However, it is up to those present today to return home and excite and enthuse fellow physicians to get involved in this legislative campaign. Sportscaster Al McGuire, while commenting on a recent basketball game, stated, "One of the teams is not playing to win, they're just trying not to lose." Well, patient care, in this instance, demands that we win. We can't be content just to go through the motions of trying not to lose.

Like a dark cloud, health costs loom as the major problem in health care. Traditionally, business supported high quality and access to medical care. In the 60s and 70s business stood shoulder-to-shoulder with medicine against labor and big government's effort to control medical care. Now, as evidenced with the recent Kentucky Workers' Compensation package, we find ourselves alone. More evidence of isolation was displayed when the Kentucky Chamber of Commerce Indigent Care Study Committee excluded representatives of the health delivery team.

For the first time, *legitimate forces* outside the legislative, bureaucratic and labor groups are lining up on the opposite side demanding action on health costs. In addition, like rats fleeing from a sinking ship, the health insurance industry has also bailed out. Years ago when physicians opposed first dollar coverage, insurance and business interests turned their collective heads. Rather than increase wages, they simply piled on the health benefits. Now the chickens have come home to roost. Unfortunately for us and our patients, the loss of insurance and business support, particularly when nonphysician practitioners seek inroads into the medical profession, has had a profound effect upon our credibility.

So long as government continues to pay a vast percentage of health costs, the old adage "he who pays the piper" will prevail. *Health costs have jokingly been referred to as the Pac Man of the budget.* Legislators, government, industry and labor will continue to search for that "pie in the sky" panacea which would change our present system to one that redresses costs yet ignores quality of care. Quite frankly, government and business frustration with rising health costs may be moving us closer to socialized medicine than anytime in our history. Forty to 50% increases in monthly health premiums are very common, even in Kentucky.

Pressure from these groups will not subside. Physicians need to recognize what this means to our livelihood and that the freedom to practice as we know it is at stake. We must confront this problem with renewed vigor and intense political activity.

That brings me down to an internal matter that concerns me—the continuing divisiveness within the profession. I was appalled by the indifference of many physicians with regard to the optometric issue. Many physicians have never understood the terrible toll the 1986 legislation had on the future of medicine. Our foes have found that the easiest and best way to bring about our demise is to divide and conquer. An inroad to one specialty is an inroad to all specialties. John Locke once said that "hell is truth—seen too late." I hope we all recognize the problem and confront it. . .before it's too late.

My mentor and good friend, Carl Cooper, always admonished us when we were critical of some inane piece of legislation by paraphrasing an old saying, "Just remember, boys, good legislation is in the eye of the beholder." If we comprehend Carl's philosophy then we understand politics and the General Assembly. As many of you know, my family has been active politically for many years. Politics is fun; politics is rewarding; politics can produce results that no other activity can. *If you don't learn to manage politics, you will be directed by it.* This is a lesson we all need to know.

Finally, a growing number of legislators are seeking to impose punitive measures upon physicians. Suddenly, we are seeing legislation prohibiting hospital admission and discharge fees; committees to study physicians' fees; requirements to submit itemized and

detailed statements above and beyond the average business statement; fee schedules, as adopted in the recent Workers' Compensation bill; mandatory participation in Medicaid/Medicare; open patient medical records laws; mandatory CME tied to licensure; and numerous other bills which we never thought possible.

What we need now is help from the local level. Only grass roots support will make this session successful, especially in the area of tort reform.

Lobbyists, in and of themselves, rarely influence major legislation, simply due to the fact that they don't *live, work or vote* in the legislator's district. They are only as effective as **we** make them by **our** participation in the elective process. We have many issues before the Kentucky General Assembly and we must be totally honest. Legislators are no longer swayed to support KMA's position based solely upon the incantation of "good medical practice" or "quality care."

The role you play can be decisive at this critical time. The few can no longer carry the burden for the medical profession. The 15% of Kentucky doctors belonging to KEMPAC may well be indicative of the attitude and interest physicians truly have. As an old fellow down home used to say, "maybe they haven't gotten into our pockets deep enough yet!"

You have heard the famous Teddy Roosevelt quote many times—but, it is worth repeating *today, tomorrow, next week*, and *next year*—or until every physician begins to hear the message.

> Every person owes part of their time and money to the business of industry in which they are engaged. No person has a moral right to withhold support from an organization that is striving to improve conditions within his sphere.

Dwight Eisenhower during a difficult period in his career said, "Life is worthwhile only if it represents a struggle for worthy causes. The human being cannot continue to exist if he has perfect security."

Well. . .our profession is far from secure. . .the task before us during this session, while not easy, is not insurmountable. In the end, the success or failure of this effort ultimately will depend upon you.

Thank you.

Donald C. Barton, MD
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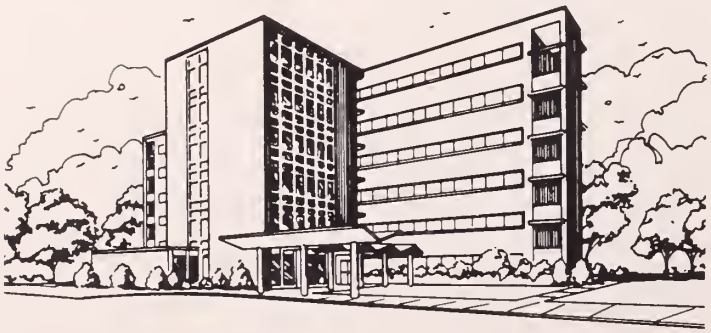
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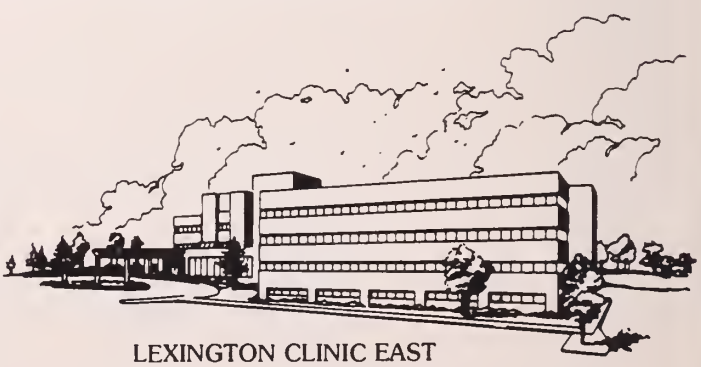
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Pyogenic Sacroiliitis — A Case Report

David T. Tao, MD

Presented is a case of pyogenic sacroiliitis (septic arthritis of the sacroiliac joint) occurring in an intravenous drug abuser. The diagnosis, treatment, and prognosis of this disease are discussed, with particular attention to the use of radionuclide bone scanning and joint aspiration/biopsy.

Case Report

A 31-year-old black female presented to the Emergency Department complaining of pain in her left buttock. One week prior to this, she had fallen on her left hip and was diagnosed as having a contusion. Her pain had gradually worsened to where she was unable to walk. She denied any systemic illness and was taking no medication.

On examination, the patient was noted to have a temperature of 103°F rectally. She complained of extreme pain in the left hip and buttock with radiation down the left thigh and calf. Physical examination was remarkable for exquisite tenderness over the left sacroiliac joint. There was no palpable fluctuance or localized area of increased warmth. Left hip flexion was markedly painful, and the left patellar reflex was absent. Lower extremity pulses and sensation were intact.

David T. Tao, MD, 2918 Kings Bridge Dr, Louisville, KY.

Admitting laboratory data was remarkable for a WBC count of 15,900. The WBC differential showed 71% segmented neutrophils, 6% bands, 18% lymphocytes, and 5% monocytes. The erythrocyte sedimentation rate was 110 (nl 0 to 20). X-ray examinations of the pelvis, lumbar spine, and chest were all interpreted as normal. Blood cultures were obtained upon admission.

Surgical consultation was obtained for evaluation of possible left gluteal abscess. Aspiration of this area was unsuccessful, and CT scanning of the pelvis showed no evidence of abscess or hematoma. Thirty-six hours after admission, one of two blood cultures grew coagulase negative staphylococci. Repeat blood cultures were obtained and the patient was begun on intravenous nafcillin. Aspiration of the left hip under fluoroscopy yielded fluid containing no cells and no organisms. Culture of this fluid was negative. The patient's temperature fluctuated between 98 and 100.2°F orally and her physical examination remained unchanged.

Gallium scan was ordered on the third hospital day. Twenty-four hour images demonstrated abnormal uptake suggestive of an infected left sacroiliac joint. Although the patient had previously denied drug abuse, further questioning revealed that she had used intravenous drugs within two weeks of her initial presentation. Aspiration of the left sacroiliac joint under fluoroscopy was performed. This yielded fluid showing a few gram positive cocci on Gram's stain, but was culture negative. Repeat aspirate of the left sacroiliac joint yielded turbid fluid which grew *Pseudomonas aeruginosa*. On the thirteenth hospital day, open biopsy of the left sacroiliac joint was performed. All biopsy samples were culture positive for *Pseudomonas aeruginosa*. Postoperatively, nafcillin was

discontinued, and therapy with mezlocillin and tobramycin was begun.

The patient's clinical status improved dramatically, and she began to ambulate. Thirty days after admission she was discharged to an extended care facility to complete a four-week course of parenteral antibiotics. Two months after admission, the patient had no clinical signs of infection and no limitations of her activity.

Discussion

Septic arthritis of the sacroiliac joint has been reported in American scientific journals as early as 1878.[1] Recent reviews of the literature show this to be a relatively uncommon entity, with fewer than 120 English language reports up to 1985.[2] Pyogenic sacroiliitis has been estimated to account for up to 1.5% of pediatric joint infections,[2] though the incidence may be higher in adult populations (particularly among intravenous drug abusers).[3] Mortality figures of 40% were reported by L'Episcopo in 1936,[1] prior to the use of antibiotic therapy. With the advent of antibiotics, it is now unusual to find a fatality from this disease.

The sacroiliac joint contains a synovial cavity which is bounded posteriorly and above by the strong interosseous sacroiliac ligament. The anterior aspect of the joint is covered by a thin ventral sacroiliac ligament which is prone to rupture when stressed. The joint cavity is occasionally divided by ridges, which may account for difficulty in aspirating infected material when only a portion of the joint is involved.[3] The afferent innervation of the joint capsule is supplied by the lower branches of the lumbosacral plexus, accounting for radicular findings in sacroiliac joint pathology. Rupture of the ventral sacroiliac ligament can allow infection to spread to the iliac fossa, where it mimics intra-abdominal abscess. Complicated infections may involve the medial or posterior thigh, hip joint, and gluteal or lumbar musculature.

Normal motion at the sacroiliac joint is very limited. However, joint mobility may increase during pregnancy with relaxation of the pelvic ligaments.[4] Both pregnancy and trauma have been implicated in the pathogenesis of pyogenic sacroiliitis, possibly by predisposing the sacroiliac joint to hematogenous seeding.[5] Skin infections, intravenous drug abuse, endocarditis, bone, and urinary tract infections have also been listed as causative factors. Staphylococci and streptococci are the most commonly reported pathogens except among intravenous drug abusers where *Pseudomonas aeruginosa* is frequently encountered.[3] (Both *Staphylococcus* and *Pseudomonas* were implicated as pathogens in the case described herein. *Staphylococcus* was isolated from the blood but not grown from sacroiliac joint aspirate, possibly because of treatment with nafcillin prior to aspiration. [Note that gram positive cocci were seen on Gram's stain of sacroiliac joint fluid.] Open biopsy confirmed the presence of *Pseudomonas* in the joint.)

Physical examination of the patient with pyogenic sacroiliitis can often be misleading. While fever and pain in the hip or buttock of the affected side are fairly constant findings, radicular signs or abdominal tenderness can direct attention away from the sacroiliac region. Passive straight leg raising is frequently painful and may suggest intervertebral disc pathology. Tenderness on passive hip motion is another common finding. This may not be consistently reproducible if testing is done slowly to avoid motion of the sacroiliac joint. Direct palpation of the sacroiliac joint is useful in finding a point of maximal tenderness. The Gaenslen (hip hyperextension) and Fabere (hip flexion, abduction, and external rotation) maneuvers place stress upon the sacroiliac joint and are nearly always painful in sacroiliitis.

Laboratory evaluation of the patient with an infected sacroiliac joint usually reveals an elevated WBC count and increased erythrocyte sedimentation rate. Initially, plain radiographs of the pelvis may demonstrate no pathologic changes. These changes may become manifest two to three weeks after the onset of symptoms and include haziness of the joint line with destruction of the cortical margins of the joint.[2,6] Radionuclide bone scanning with Gallium or Tc-99 pyrophosphate has been extremely useful in early diagnosis. When positive, these scans show increased uptake by the affected sacroiliac joint. Up to two-thirds of patients may have a positive scan within the first week of their illness, and virtually all scans obtained after the first week are positive.[5]

Identification of the pathogens involved in pyogenic sacroiliitis may be accomplished by blood culture, joint aspiration, or open biopsy. Blood cultures are positive in 38% to 80% of acutely ill patients.[2,5] Patients with a "subacute" or "chronic" history of illness have fewer positive blood cultures. Attempts at bedside aspiration of the sacroiliac joint have generally given poor results, while aspiration under fluoroscopic control has yielded culture positive material in up to 87% of cases.[3] (It should be noted that the best results with

aspiration were reported by a center frequently utilizing this technique on a population composed largely of drug abusers.) Open biopsy of the sacroiliac joint is indicated when bacteriologic diagnosis cannot be made by other means, or when a lack of response to antibiotics suggests the presence of resistant organisms.

The treatment of pyogenic sacroiliitis, when not complicated by abscess or sequestrum formation, is accomplished by the administration of high-dose intravenous antibiotics. The choice of antimicrobial agent is guided by culture and sensitivities of the involved pathogens. Pending bacteriologic studies, empiric therapy may be instituted using anti-staphylococcal agents with the possible addition of an aminoglycoside (important for *Pseudomonas* coverage in drug abusers). Parenteral therapy for four to six weeks is recommended to prevent periarticular osteomyelitis.[5] In cases complicated by abscess or sequestrum formation, surgical drainage is necessary in addition to the use of antibiotics. Cast immobilization is seldom indicated because of the limited motion of the sacroiliac joint.

Before the use of antibiotic therapy, pyogenic sacroiliitis had a 30% to 40% mortality rate.[1,7] Today this disease is rarely fatal and most patients have no loss of function after treatment. Recurrence is rare, but has been reported in patients receiving less than four weeks of parenteral antibiotics.[5]

In summary, pyogenic sacroiliitis can mimic a variety of other disorders, including herniated lumbar disc and intra-abdominal abscess. Correct diagnosis is facilitated by careful examination of the sacroiliac joint and the use of radionuclide bone scanning. Blood cultures may identify the pathogen(s) involved, though joint aspiration or biopsy may be necessary. Empiric treatment should begin with anti-staphylococcal agents, but should also include gram-negative (*Pseudomonas*) coverage in drug abusers. Barring complications, patients receiving an adequate course of antibiotic therapy recover with minimal morbidity.

Acknowledgment

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Percutaneous Balloon Aortic Valvuloplasty

G.S. Sohi, MD; Humberto Coto, MD; Abraham Joseph, MD

The well-established treatment of a severe hemodynamically significant aortic stenosis is aortic valve replacement. However, there are a considerable number of patients where risk from surgery is prohibitive because of old age, general debilitation, poor left ventricular function, or other illnesses, namely, malignancies and chronic obstructive airway disease. Therefore, these patients are either unsuitable or unwilling to undergo open-heart surgery. Recently, extension of the technique of percutaneous transluminal coronary angioplasty has been applied to the aortic valve. The aortic valve is dilated percutaneously with a specially designed, balloon-tipped catheter, thus producing palliative valvuloplasty. This report describes such a patient who had hemodynamically significant and symptomatic calcific aortic stenosis but was not a candidate for aortic valve replacement because of severe lung disease and tracheal stenosis. A 20 mm balloon was percutaneously positioned across his stenotic valve and the valve dilated. The mean systolic gradient across the valve was immediately reduced from 71 mm Hg to 20 mm Hg. The calculated valve area doubled in size from 0.46 cm^2 to 0.95 cm^2. The patient suffered no complications. Over a 13-month period he has been asymptomatic and there has been no evidence of worsening of his aortic stenosis.

Work performed when senior author was a faculty member at the University of Louisville School of Medicine. Present address: GS Sohi, MD, Director Cardiac Catheterization Laboratory, Norton Hospital, 225 Abraham Flexner Way, Louisville, KY 40202.

Introduction

Since the introduction of transluminal coronary angioplasty by Gruntzig in September of 1977,[1] the application of percutaneous balloon dilatation procedures has been expanded to include renal artery stenosis,[2] peripheral vascular disease,[3] and certain stenosed cerebral vessels.[4] More recently, this procedure has been further expanded to include balloon dilatation of congenital stenosis of the pulmonary valve,[5] coarctation of the aorta,[6] and severe aortic stenosis in the neonate.[7] Percutaneous catheter commissurotomy of rheumatic mitral stenosis has also been performed successfully.[8] The recent application of this technique to hemodynamically significant, severe calcific aortic stenosis in elderly patients who are unsuitable or unwilling candidates for aortic valve replacement holds a great promise.[9]

We report our experience with an elderly patient who underwent successfully a percutaneous balloon aortic valvuloplasty (PBAV) for severe calcific aortic stenosis.

Case Report

A 66-year-old male began to have syncopal episodes in 1985, sustaining a hip fracture during one of these episodes. In December of 1986, a continuous wave Doppler and a 2-D echocardiogram revealed severe calcific aortic stenosis.

There was no history of congestive heart failure, angina pectoris, rheumatic heart disease or hypertension. The patient was a heavy smoker with severe chronic lung disease and was on continuous oxygen therapy. His history included past episodes of respiratory failure and a previous tracheostomy resulting in tracheal stenosis.

TABLE 1
HEMODYNAMIC DATA

Site	Pressures (mm Hg) Baseline	Post PBAV
RA (mean)	5	7
RV	35/7	35/7
PA	30/15	30/20
PCW (mean)	7	12
LV	225/10**	180/18***
AO	156/68*	
FA	160/68* 148/60**	160/62***
Measured or Calculated Data		
E.T./sec	0.36	0.37
Peak systolic gradient mmHg (LV vs FA)	77	20
Mean gradient (mmHg)	71	20
CO	4.70	5.63
AVA cm^2	0.46	0.95

RA - right atrium
RV - right ventricle
PA - pulmonary artery
PCW - pulmonary capillary wedge pressure
LV - left ventricle
AO - ascending aorta
FA - femoral artery
ET - ejection time
CO - cardiac output
AVA - aortic valve area

* - simultaneous
** - simultaneous
*** - simultaneous

A physical examination revealed a grade 3/6 ejection systolic murmur at the aortic area radiating to the carotid vessels and a similar 2/6 systolic murmur at the apex. The carotid pulses were diminished.

An electrocardiogram showed left ventricular hypertrophy and a chest x-ray was consistent with chronic pulmonary disease.

A cardiac catheterization showed a severe calcific aortic stenosis. A left ventriculogram showed normal ventricular contractility and minimal mitral insufficiency. The coronary arteries were free of significant atherosclerosis except for a small second obtuse marginal branch which was diffusely diseased.

Routine laboratory analysis was unremarkable. Arterial blood gases showed a pH of 7.36, pO_2 of 52 mm Hg, and pCO_2 of 64 mm Hg.

The patient was evaluated by a surgical team. However, because of severe chronic lung disease, and thus prohibitive surgical risk, aortic valve replacement was not performed. The patient consented to undergo percutaneous balloon aortic valvuloplasty (PBAV).

Methods

After an informed consent was obtained, with the surgical team on standby, on December 19, 1986, the patient was brought to the catheterization laboratory where mild sedation was administered intravenously. Right heart catheterization was accomplished from the left groin with a No. 7.5F Swan Ganz catheter. Right heart hemodynamics including thermodilution cardiac output were obtained (Table 1). The left femoral artery was also cannulated with an 8 French sideport sheath for continuous femoral pressure recording. The right femoral artery was then cannulated via the Seldinger technique and a 7F multipurpose catheter was advanced to the ascending aorta. Both arterial pressures were then compared and systemic anticoagulation was obtained with a bolus of 7,500 units of heparin.

The aortic valve was crossed retrogradely with a 0.038 straight guidewire and the catheter was advanced into the left ventricle. Left heart hemodynamic measurements were obtained (Table 1). Simultaneous

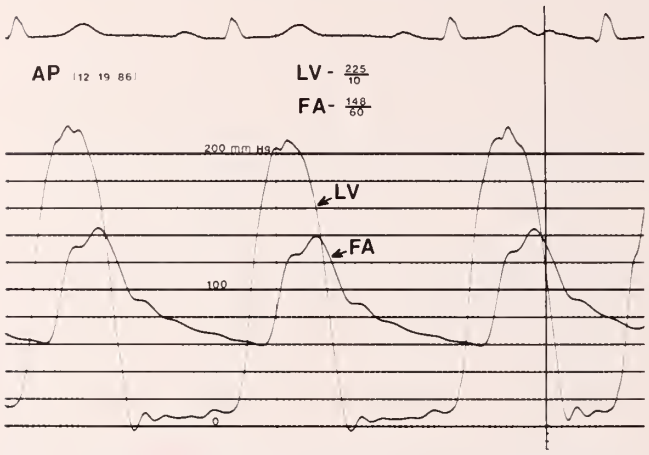


Fig 1. Simultaneous left ventricular (LV) and femoral artery (FA) pressures immediately before valvuloplasty, showing 77 mm Hg peak gradient.

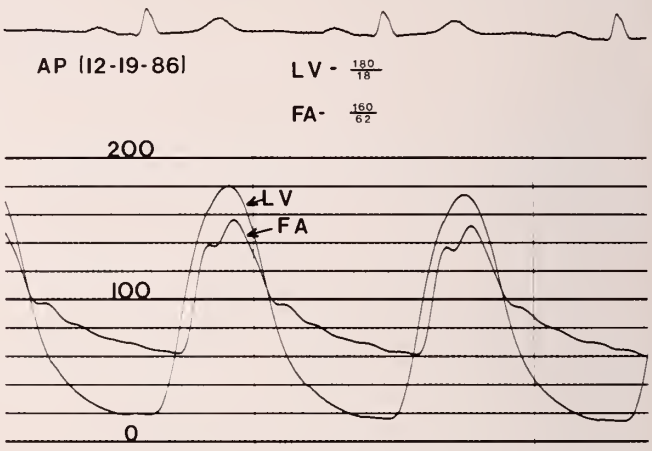


Fig 2. Simultaneous LV and FA pressures after valvuloplasty showing the reduction of peak gradient to 20 mm Hg.

femoral artery and left ventricular pressures are shown in Fig 1.

A 300-cm 0.038 "J" exchange wire was advanced through the multi-purpose catheter into the left ventricle and the catheter was removed. A 20 mm diameter, 4.5 cm long balloon valvuloplasty catheter (Mansfield Scientific, Inc.) was advanced over the guidewire and positioned by use of fluoroscopy at the level of the calcified aortic valve. The balloon was hand-inflated with saline and Renografin in equal proportion up to 3 atmospheres of pressure for 20 seconds until the initial indentation noted at the beginning of inflation disappeared (Figs 3 and 4). Electrocardiogram, arterial, and pulmonary artery pressures were monitored continuously. Following this, simultaneous femoral artery and ventricular pressures were recorded (Fig 2) and cardiac output measured again.

Blood loss was minimal and the patient was discharged from the hospital five days later in an improved condition.

Results

Immediate hemodynamic parameters showed a marked improvement following the valvuloplasty. Peak-to-peak systolic gradient decreased from 77 mm Hg to 20 mm Hg, while the aortic valve area increased[10] from 0.46 cm^2 to 0.95 cm^2. The cardiac output rose from 4.70 L/min to 5.63 L/min.

During inflation, no chest pain or loss of consciousness occurred, though frequent premature ventricular beats developed. There was no evidence of embolic phenomena or aortic insufficiency. The clinical course was uneventful. However, because of the patient's severe lung disease, a functional exercise stress test could not be performed. More than 13 months after the procedure, the patient continues to do well from the cardiovascular point of view, without signs of restenosis.

Discussion

Calcific aortic stenosis in the elderly is a relatively common occurrence, and when associated with symptoms, aortic valve replacement (AVR) is warranted. Associated medical problems and depressed left ventricular function represent a higher surgical risk with an increased incidence of morbid events.[11] PBAV is an alternative palliative procedure with immediate relief of transvalvular gradient. Although recently introduced, the use of valvuloplasty for calcific aortic stenosis is increasing and preliminary results are encouraging.[12,13,14]

Although this procedure is currently considered a palliative measure, it might become the treatment of choice in high surgical risk patients who have significant calcific aortic stenosis or who are unwilling to undergo AVR. Balloon valvuloplasty improves aortic stenosis by separating fused commissures, fracturing calcifications or stretching open such rigid valve cusps.[12]

This procedure is considered successful when a full dilatation of the balloon is achieved with disappearance of the initial indentation. Additionally a peak-to-peak gradient decrease of at least 50% with a similar increase of valve area is expected.

Although this is a safe procedure, PBAV is con-

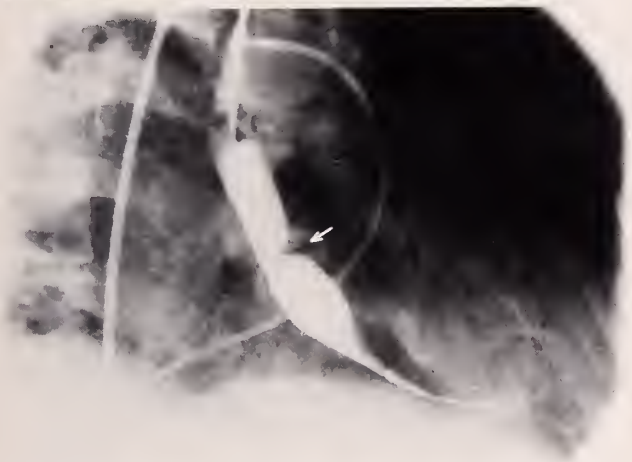


Fig 3. A partially inflated balloon across the aortic valve showing indentation (waist) at the site of the stenotic valve cusps (arrow).

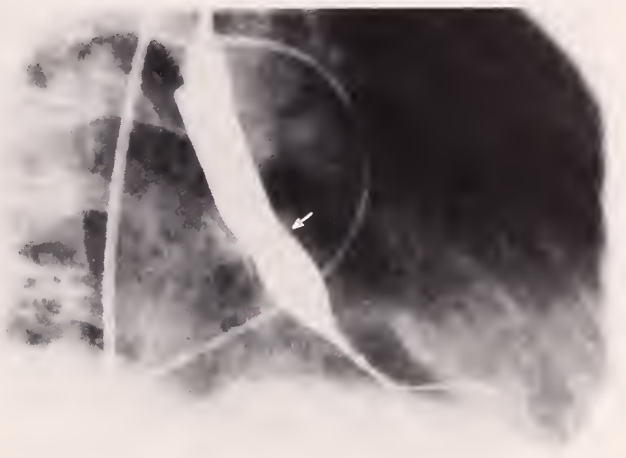


Fig 4. Fully inflated balloon with disappearance of the waist indicating opening of the valve (arrow).

traindicated in severe aortic insufficiency (AI) and bleeding disorders.

The complications which may occur at the time of valvuloplasty include transient hypotension, blood loss, vascular trauma, ventricular arrhythmias, perforation of a cardiac chamber leading to tamponade, acute aortic insufficiency, cerebrovascular accidents, and death.[12,13,14]

It appears that the transitory hypotension noted during inflations develops from outflow tract blood flow obstruction. However, despite full balloon inflation with resultant occlusion of the ventricular outflow track, some blood is presumably delivered to the systemic circulation around the balloon. In addition, acute transient mitral regurgitation, if already present, probably develops or worsens, producing a protective mechanism for acute severe left ventricular dilatation during balloon obstruction. Our patient tolerated the drop in systemic blood pressure without consequence.

Ventricular arrhythmias, such as frequent premature beats and episodes of non-sustained ventricular tachycardia, may be the result of ventricular ectopic activation by the wire or catheter in the left ventricle during inflations. This phenomenon is transient and, to date, does not appear to be of consequence.

Acute aortic insufficiency may result from tearing off the aortic cusps. Although not common, this may be a consideration, and if not contraindicated, an aortic root angiogram should be obtained post PBAV. Echocardiograms were used to compare the degree of pre-PBAV to post-PBAV aortic regurgitation in this patient.

While the long-term results of PBAV are not known, re-stenosis is known to occur.[13,14] Furthermore, if patients improve and stabilize after PBAV, becoming better candidates for AVR, operative intervention, if warranted, should be considered at that time. Apparently, calcium or blood clot embolic phenomena do not appear to be a clinical problem in individuals with severely calcified aortic valves.[13,14]

The procedure is new and a great deal more needs to be learned about it. New knowledge and new catheter technology are likely to make it safer and more effective. Its application may increase in the future.[15,16]

Conclusion

In summary, our patient showed an immediate hemodynamic improvement which is consistent with results of previously reported patients. Although further clinical trials are needed before this technique can be considered an alternative to AVR, PBAV may be the procedure of choice in individuals with critical aortic stenosis who represent an unreasonably high risk for surgical intervention, or who decline such an operation.

Addendum

The senior author has performed another 13 such procedures with good immediate results. In two additional patients the aortic valve could not be crossed with the balloon because of tortuous vessels.

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Recurrent Sulfonylurea Induced Nocturnal Hypoglycemia Managed with Tolbutamide

George C. Borst, III, MD

Sulfonylurea drugs are commonly used to treat Type II diabetes in elderly patients, but they can induce serious hypoglycemic reactions. Two cases of severe sulfonylurea induced recurrent nocturnal hypoglycemia are reported which responded favorably to treatment with the shortest-acting sulfonylurea, tolbutamide.

Introduction

Seventy-five to eighty-five percent of diabetic patients have Type II or non-insulin dependent diabetes mellitus. These patients usually have combined defects of reduced or limited insulin secretory reserve and resistance to the action of insulin on target tissues.[1,2] Sulfonylurea drugs play an important role in the treatment of Type II diabetes because they partially correct these defects.[3] They augment islet cell insulin secretion and increase tissue sensitivity to insulin. The available sulfonylurea drugs differ from one another with regard to their hypoglycemic potency (dose range), their half-life, and their duration of action.[3,4] These drugs are metabolized to inactive or weakly active compounds by the liver and excreted by the kidneys. As a group they have a low incidence of side effects. However, one of their most common and potentially severe adverse effects is the induction of hypoglycemia. Hypoglycemia has been reported most commonly with chlorpropamide[5] and more recently with glyburide therapy,[6] but may occur with all drugs in this class.[3] Recurrent severe nocturnal hypoglycemia occurred in two diabetic patients treated with sulfonylureas who were later treated successfully with tolbutamide.

Presented to the American College of Physicians, Regional Meeting, Lexington, KY, October, 1986. *George C. Borst III, MD, Internal Medicine and Endocrinology, 1201 St Christopher Dr, Ashland, KY 41101.*

Case Reports

Case I: A 90-year-old woman was hospitalized in August of 1984 with severe nocturnal neuroglycemia and a blood glucose of 33 mg/dl while receiving tolazamide (Tolinase) 250 mg daily. She was then placed on glipizide (Glucatrol) 10 mg bid but presented again approximately one month later with severe nocturnal hypoglycemia, glucose 37 mg/dl. The patient resided in a nursing home and her medication was administered by the staff. In addition to the oral hypoglycemic, she also received Lanoxin, Lasix, and Bactrim. There was a history of longstanding diabetes mellitus and atherosclerotic disease. Physical examination revealed a confused elderly woman, height 60 inches, weight 128 pounds. Vital signs were normal and general physical examination was unremarkable. There were no focal neurological deficits and no evidence of congestive heart failure. Laboratory evaluation revealed a normal complete blood count, creatinine 1.4 mg/dl, BUN 24 mg/dl, alkaline phosphatase 334 U/1 (normal 86-263) and SGOT 30 U/1 (normal 6-32). Fasting serum insulin was less than 3.0 mcu/1 with a blood glucose of 217 mg/dl and stimulated to 11.2 mcu/ml after a 75 gram oral glucose challenge (maximal blood glucose 352 mg/dl). During her second hospitalization, the patient was treated with tolbutamide (Orinase) 500 mg twice daily and her blood glucose stabilized in the 150 to 300 mg/dl range. There were no further episodes of hypoglycemia.

Case II: An 83-year-old male was hospitalized in October of 1983 with severe nocturnal hypoglycemia while treated with Diabinese 500 mg each morning. He was unarousable on the morning of admission and was brought to the emergency room where a blood glucose was 35 mg/dl. The patient was treated with intravenous dextrose and his mental status improved. On physical examination the patient appeared as a thin, healthy 83-year-old male, height 69 inches and weight 130 pounds. Physical examination was normal

with the exception of decreased vibratory sensation in the lower extremities consistent with diabetic neuropathy. He had no chronic illness and his renal function and liver function tests were normal. The patient took Dramamine and Valium occasionally for treatment of vestibular dysfunction. During hospitalization the Diabinese was decreased to 250 mg daily and there were no further hypoglycemic reactions, though it was noted that the patient's blood glucose was frequently elevated during the late afternoon and evening with his fasting blood glucose consistently being the lowest of the day. His glycohemoglobin level was 6.5%. During hospitalization the patient was instructed in home capillary glucose monitoring. Shortly after he returned home he began noting lower fasting blood glucose readings, as low as 58 mg/dl. The patient was instructed to discontinue chlorpropamide, but his blood sugars began rising and were frequently above 200 mg/dl. Tolbutamide (Orinase) 250 mg each morning was prescribed. On this regimen his blood sugars ranged between 100 and 160 mg/dl and there were no further hypoglycemic reactions. A glycohemoglobin level six months later was 6.1%.

Discussion

These cases demonstrate the well-known dangers of hypoglycemia in elderly patients treated with sulfonylurea drugs. In addition to age, other high risk groups include patients with renal or hepatic dysfunction, poor nutrition, and patients taking certain medications or alcohol (Table 1). Hypoglycemia occurs most frequently with the sulfonylureas having the longest plasma half-life and the longest duration of action (chlorpropamide and glyburide).[5,6] This was the case in patient II who seemed to have a delayed onset of action of chlorpropamide leading to hyperglycemia during the day and low blood glucose at night. However, case I reminds us that sulfonylureas with short or intermediate plasma half-lifes (glipizide and tolazamide) also can produce severe neuroglycemic episodes. The clinical presentation often misleadingly suggests a primary neurological disorder. Glipizide therapy has been reported to have a low frequency of hypoglycemia.[7,8] This is the first report of severe nocturnal hypoglycemia in a patient receiving glipizide. The patient was quite elderly and had mild hepatic and renal dysfunction which may have contributed to the prolonged duration of hypoglycemic activity. Hypoglycemia ceased in both patients when treated with tolbutamide, the sulfonylurea with the shortest duration of action. This drug has a plasma half-life of four hours and a duration of action ranging from six to 12 hours. This shorter duration of action allowed treatment of hyperglycemia during the day without induction of nocturnal hypoglycemia in these cases. In patient II a single daily dose achieved good glucose control throughout the day and night, while in patient I twice daily dosing was required for modest glucose control. Weaker hypoglycemic activity and the need for frequent dosing are factors that have contributed to a decline in the utilization of tolbutamide. Ironically these characteristics were uniquely beneficial in the treatment of the cases reported. These are the first reports of cases where the pharmacodynamics of tolbutamide proved beneficial in preventing recurrent nocturnal hypoglycemia induced by longer acting sulfonylureas.

TABLE 1

RISK FACTORS FOR HYPOGLYCEMIA WITH SULFONYLUREA DRUGS

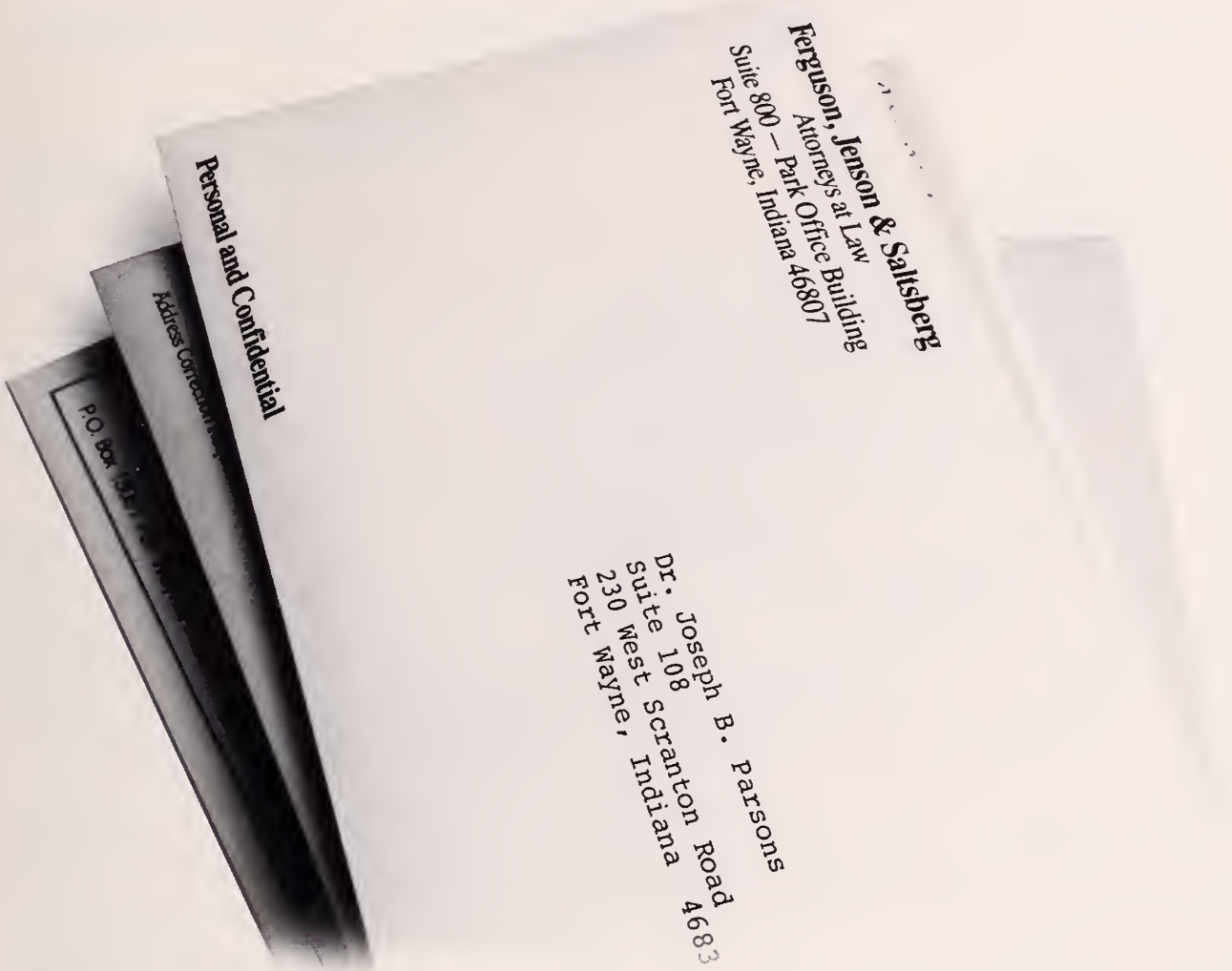
1. Elderly patients
2. Hepatic or renal disease
3. Poor nutrition
4. Other medications (phenylbutazone, warfarin, sulfa drugs, aspirin)
5. Alcohol
6. Long duration of action (chlorpropamide and glyburide)

Summary

Sulfonylureas with intermediate duration of action (tolazamide or glipizide) can produce serious nocturnal hypoglycemia. The oral hypoglycemic drug with the shortest duration of action (tolbutamide) may be useful in the treatment of patients with recurrent hypoglycemia while treated with longer acting sulfonylureas.

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EDITORIAL

Century after century some pestilence consumed our people. Plague spread in the cities and towns, where rodents and insects could be mighty vectors. Sanitation methods and some public health measures removed the threat, after many perished.

Pox was a formidable enemy, striking young and old with little sympathy. Vaccination, introducing an attenuated form of the enemy, would now in this century finally banish this dreaded culprit.

Antisepsis ushered in the era when much of what we physicians can do will help rather than harm. Procedures are accomplished, wounds tended to, babies born and parts removed without leaving a residue of injury.

Rows of dormant iron lungs, millions still lame and disabled, subtle neurological deficits and sad remembrances of gone loved ones are all that remain of polio. Salk and Sabin discovered a prophylaxis for this malady, which seemed in the late 40s and early 50s to be hopeless.

German chemists discovered that sulfa could be used therapeutically. Infections started to yield to some form of control.

Operations are still mending the hearts of brethren that from years past bear the scars of rheumatic fever on valves and walls. From the throat to the core, somehow bacteria and their residue wreaked havoc, at first silently and deceitfully, then heard in the stethoscope and seen on the films. Yet mold growing peacefully on media produced a weapon, penicillin, more potent than ever seen before, and the infection became vulnerable. Syphilis yielded to this bullet, dramatically changing the public health field.

Chemotherapy for tuberculosis and schizophrenia cleared the human warehouses where the unfortunate were exiled.

Now AIDS is the villain at hand. From Africa to Haiti, from the drug user to the indiscriminate airplane steward, the epidemic has spread. Reminiscent of days ago we frantically call for isolation, barrier prevention, public awareness, etc. All the while our numbers dwindle at what seems to be a logarithmically increasing speed. Our best minds are working feverishly for the discovery that will end this latest scourge. The medical community must advocate the scientific rather than the judicial role, encouraging government and private research. This is no time to bury our heads hoping that merely condemning those afflicted for their behavior or avoiding contact with vectors will dissipate the affliction.

Our predecessors would compare our fear with what they felt with their epidemics. With no end in sight, many dying, transmission rampant, these doctors worked to overcome their adversary. Future generations will look back on this time and learn from our accomplishments. Cool heads, scientific encouragement, sympathy for the sick and working our healing ways are the tools for this task.

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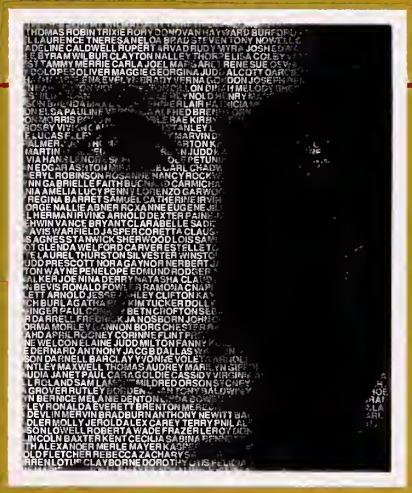
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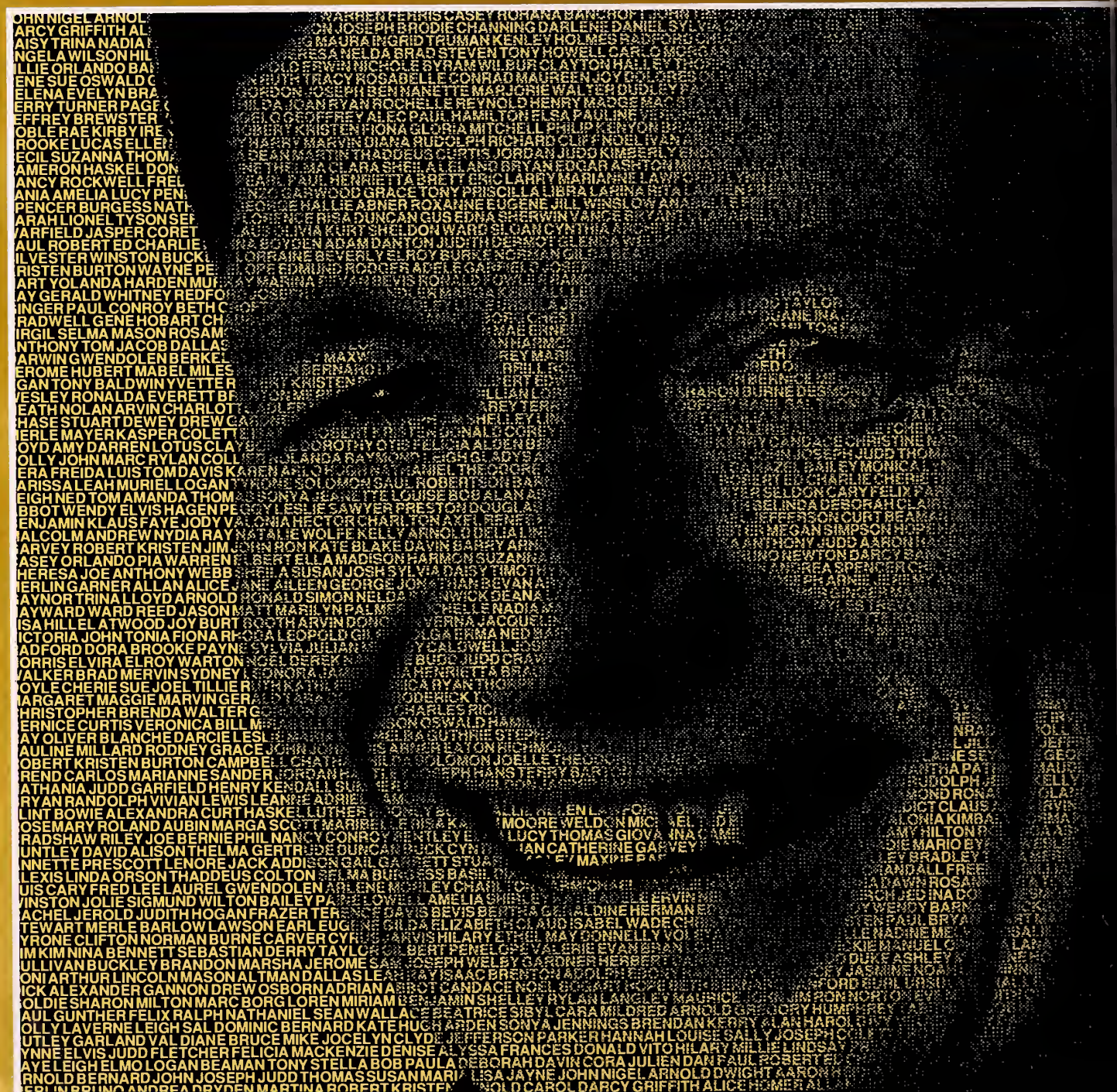
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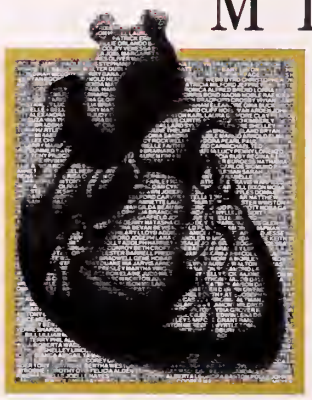
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DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

D7295 188

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All Aboard For Convention



In keeping with the AKMA theme for 1987–88, "Today's Visions Are Tomorrow's Realities," auxilians left the 1987 Convention with the determination of 'The Little Engine That Could." During this Auxiliary year, we have remained on the right track.

All auxilians are invited to meet April 25–27 at the Quality Inn in Ashland for the 66th Annual Convention of the Auxiliary to the Kentucky Medical Association to celebrate the many accomplishments we have achieved because "we thought we could."

AKMA Convention Chairman Ginny Hauswald and her hard-working committee are finalizing plans for what promises to be a very enjoyable and productive meeting. In addition to the regular meetings of the AKMA Board and the House of Delegates, Auxilians will be offered a wide variety of activities from which to choose including workshops, tours, golf, tennis, shopping at AKMA's new fundraising project, "The Company Store," and an evening at the Paramount Arts Center with special guest speaker Ann Jillian (auxilians will have an opportunity to meet Miss Jillian at the AKMA reception Tuesday evening).

Reservation forms and pre-registration information are included in the March issue of the *Bluegrass News*.

I look forward to seeing each of you at convention.

Pamela H. Potter
AKMA President

Calendar of Events (Tentative)

Sunday, April 24 (EST)

2:00 PM	Check in at hotel
7:00 PM	Hospitality Room open, President's Suite

Monday, April 25

7:00 AM	Complimentary Continental Breakfast served until mid-morning, Concierge Lounge Delegate registration, Mezzanine Level
9:00 AM	Committee meetings, Board Room, Mezzanine Level
Noon	Hospitality Room open, President's Suite
Afternoon	Tennis, golf, tours, workshops available to interested auxilians.
6:00 PM	Hospitality Room closes
6:30 PM	Dinner honoring 1987–88 Board, cash bar Hotel Ballroom
8:00 PM	AKMA Board Meeting, Hotel Ballroom Hospitality Room reopens immediately following the Board Meeting

Tuesday, April 26

7:00 AM	Complimentary Continental Breakfast Concierge Lounge Delegate registration, Mezzanine Level
9:00 AM	House of Delegates convenes, Hotel Ballroom
1:30 PM	Luncheon for Delegates, Ashland Oil, Inc. Headquarters, limited seating. Greetings from John Hall, CEO, Ashland Oil. Brief tour of Headquarters. Free transportation provided.
5:30 PM	Reception honoring President-Elect Carol Franks and the 1988–89 Board, Board Room Mezzanine Level
6:30 PM	Installation Dinner, Hotel Ballroom
8:00 PM	Guest speaker, Ann Jillian, Paramount Arts Center
10:00 PM	Hospitality Room opens

Wednesday, April 27

7:00 AM	Complimentary Continental Breakfast Concierge Lounge
9:30 AM	Post Convention Board Meeting, Board Room, Mezzanine Level
Noon	Check-out time

The Company Store will be open throughout the Convention. Store hours will be posted in the Hospitality Room and at the Registration table.

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YOHIMBINE HCl

Description: Yohimbine is a 3a-15a-20B-17a-hydroxy Yohimbine-16a-carboxylic acid methyl ester. The alkaloid is found in Rubaceae and related trees. Also in Rauwolfia Serpentina (L) Benth. Yohimbine is an indolalkylamine alkaloid with chemical similarity to reserpine. It is a crystalline powder, odorless. Each compressed tablet contains (1/12 gr.) 5.4 mg of Yohimbine Hydrochloride.

Action: Yohimbine blocks presynaptic alpha-2 adrenergic receptors. Its action on peripheral blood vessels resembles that of reserpine, though it is weaker and of short duration. Yohimbine's peripheral autonomic nervous system effect is to increase parasympathetic (cholinergic) and decrease sympathetic (adrenergic) activity. It is to be noted that in male sexual performance, erection is linked to cholinergic activity and to alpha-2 adrenergic blockade which may theoretically result in increased penile inflow, decreased penile outflow or both.

Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

Reportedly, Yohimbine exerts no significant influence on cardiac stimulation and other effects mediated by B-adrenergic receptors, its effect on blood pressure, if any, would be to lower it; however no adequate studies are at hand to quantitate this effect in terms of Yohimbine dosage.

Indications: Yocon® is indicated as a sympathicolytic and mydriatric. It may have activity as an aphrodisiac.

Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

How Supplied: Oral tablets of Yocon® 1/12 gr. 5.4 mg in bottles of 100's NDC 53159-001-01 and 1000's NDC 53159-001-10.



References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

Rev. 1/85

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THE AGE OF MIRACLES Medicine and Surgery in the Nineteenth Century

Guy Williams
Academy Chicago, Publishers
425 North Michigan Avenue
Chicago, IL 60611
$16.95 (cloth); $8.95 (paper)

Nineteenth century medicine was ripe for change. Some evolution was beginning to ferment by the end of the eighteenth century. Human anatomy was finally well described and accepted in textbooks. Physiology was investigated scientifically, in Germany and England particularly, and the icons of the past were being discarded with some reluctance.

John Hunter and his *Treatise* educated the medical community as never before. Soon followed work on anesthesia which further permitted investigation into the human condition. The introduction of antisepsis permitted the development of surgical and hospital medicine, which heretofore was Dark Ages vintage. Obstetrical care was revolutionized by these happenings, with the subsequent reduction in maternal death and enhancement of neonatal survival.

Orthopedic care became possible, fitting the need from the battlefront, and subsequently from the general population. Inventing devices and dealing with fractures became sophisticated enough to rescue limbs and ensure some mobility. Blood transfusions and scientific exploration of the hematology field were an integral part of this care.

Transportation had evolved and distant lands were explored. Tropical medicine arose from the very difficulty of coping with foreign diseases and organisms. People could also visit spas for convalescence and treatment, with the economic progress making this possible.

Closing out this marvelous array of discoveries was that of X-ray and radium, which allowed diagnosis to reach new frontiers and treatment to tackle some difficult problems.

Those of us who love medicine will enjoy reading our history. Guy Williams, an English author and son of a physician, comfortably writes with the feeling of heralding the past medical heroes and suggesting that we will have our contemporary ones.

Stephen Z. Smith, MD

This space contributed as a public service.

Give yourself a hand against breast cancer



Breast self-examination is easy, takes only a few minutes and can be performed in the privacy of your own home. It's an important way you can detect early and highly curable breast cancer. Through monthly breast self-examinations, you will learn how your normal breast tissue feels and will be able to recognize a change if one occurs. In fact, most breast lumps are found by women themselves.

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CARAFATE®
(sucralfate)

BRIEF SUMMARY

CONTRAINDICATIONS
There are no known contraindications to the use of sucralfate.

PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that the simultaneous administration of CARAFATE with tetracycline, phenytoin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. The clinical significance of these animal studies is yet to be defined.

Carcinogenesis, Mutagenesis, Impairment of Fertility: No evidence of drug-related tumorigenicity was found in chronic oral toxicity studies of 24 months' duration conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies have not been conducted.

Pregnancy: Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients, adverse effects were reported in 121 (4.7%). Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

While healing with sucralfate may occur during the first week or two, treatment should be continued for 4 to 8 weeks unless healing has been demonstrated by x-ray or endoscopic examination.

HOW SUPPLIED
CARAFATE (sucralfate) 1-gm pink tablets are supplied in bottles of 100 and in Unit Dose Identification Paks of 100. The tablets are embossed with MARION/1712. Issued 3/84

References:

1. Korman MG, Shaw RG, Hansky J, et al: *Gastroenterology* 80:1451-1453, 1981.
2. Korman MG, Hansky J, Merrett AC, et al: *Dig Dis Sci* 27:712-715, 1982.
3. Brandstaetter G, Kratochvil P: *Am J Med* 79(suppl 2C):36-38, 1985.
4. Marks IN, Wright JP, Gilinsky NH, et al: *J Clin Gastroenterol* 8:419-423, 1986.
5. Lam SK, Hui WM, Lau WY, et al: *Gastroenterology* 92:1193-1201, 1987.

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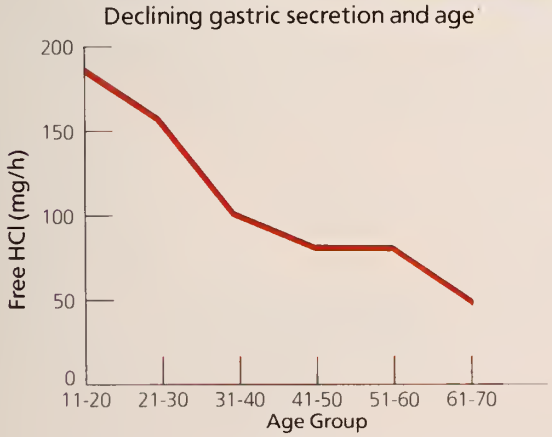
Specialized ulcer therapy

When advancing age signals reduced acid secretion



If your duodenal ulcer patient is over 55, decreased mucosal resistance is more likely to cause an ulcer than hypersecretion of acid-pepsin.[1] A tendency toward lower acid secretion with advancing age has been shown.[2,3]

Declining gastric secretion and age[1]



CARAFATE® (sucralfate/Marion) makes sense as initial ulcer therapy for the elderly. Carafate provides ulcer healing rates comparable to H_2 antagonists without the risk of systemic side effects or drug interactions—an important benefit for older patients.

The unique, nonsystemic action of Carafate enhances the body's own ulcer healing ability, strengthening the mucosal structure as it protects damaged tissue from further injury.

When advancing age signals reduced acid secretion, choose the specialized ulcer therapy of safe, nonsystemic Carafate.

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Please see adjoining page for references and brief summary of prescribing information.

1595H7



Soon more than a million.

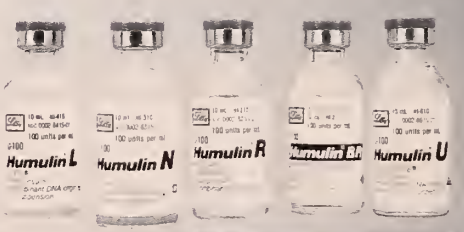
Soon more than a million insulin users will be taking Humulin.

And no wonder. Humulin is identical to the insulin produced by the human pancreas—except that it is made by rDNA technology.

Humulin is not derived from animal pancreases. So it contains none of the animal-source pancreatic impurities that may contribute to insulin allergies or immunogenicity.

The clinical significance of insulin antibodies in the complications of diabetes is uncertain at this time. However, high antibody titers have been shown to decrease the small amounts of endogenous insulin secretion some insulin users still have. The lower immunogenicity of Humulin has been shown to result in lower insulin antibody titers; thus, Humulin may help to prolong endogenous insulin production in some patients.

Any change of insulin should be made cautiously and only under medical supervision. Changes in refinement, purity, strength, brand (manufacturer), type (regular, NPH, Lente®, etc), species/source (beef, pork, beef-pork, or human), and/or method of manufacture (recombinant DNA versus animal-source insulin) may result in the need for a change in dosage.



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Neuroscience Update for the Primary Care Physician

Date
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Edward Laws, M.D.,
George Washington University Medical Center
Russell Portenoy, M.D.
Memorial Sloan-Kettering Cancer Center
Martin Samuels, M.D.
Harvard Medical School
Objective
Course will provide a neuroscience update for physicians specializing in family and general practice, internal medicine, neurology and neurosurgery.
Program Highlights
- Treatment of seizures
- Early diagnosis, classification and on-going treatment of strokes
- Early detection of brain tumors: surgical and non-surgical treatment
- Pharmacologic management of pain

Registration
Physicians — $25
Others — $15
Accreditation
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Location
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Post-Conference Event
Opening day at Churchill Downs
Information
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Neuroscience Center of Excellence
Humana Hospital – Audubon
One Audubon Plaza Drive
Louisville, Kentucky 40217
(502) 636-7087

NEUROSCIENCE CENTER OF EXCELLENCE
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Highlights of December KMA Board Meeting

The KMA Board held its second meeting of the Associational year on December 16–17, 1987, and the 1988 Kentucky General Assembly and professional liability insurance were the focus of several reports presented. S. Randolph Scheen, MD, Secretary-Treasurer, reported that officers and staff had been busy preparing for the 1988 legislative session, and Pamela Potter, President of the Auxiliary to KMA, reported that the Auxiliary would host a "Day at the Capitol" in February.

Richard F. Hench, MD, a member of the Kentucky Liability Insurance Task Force, reported that the Task Force had issued its final report containing 35 recommendations. The Board empowered the Legislative and Quick Action Committees to support the Task Force Report in all aspects that are not in conflict with any current KMA policy. The Board also endorsed the application for a grant from the Robert Wood Johnson Foundation to study the no-fault medical malpractice plan, authored by Carl L. Wedekind, Jr.

Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities, noted that KMA would conduct a Legislative Seminar in Frankfort on January 6, 1988, featuring leadership of the Kentucky General Assembly. Doctor Montgomery reported on numerous legislative issues, and the Board voted to oppose a Board of Nursing regulation that permitted ARNPs to encroach into the practice of medicine.

President Donald C. Barton, MD, reported on the AMA Interim Meeting just completed, and the Commis-



KMA Board members with Chairman William B. Monnig, MD (head of table), and President Donald C. Barton, MD (standing at microphone).



KMA President-Elect Bob M. DeWeese, MD, Louisville.

sioner for Health Services, Carlos Hernandez, MD, discussed AIDS and other matters of current interest under his jurisdiction.

John Llewellyn, MD, Secretary of the Board of Medical Licensure, reported in some detail on the Board's activities, and a question and answer session followed. Doctor Montgomery was appointed to serve as KMA's representative on an ad hoc committee of the Board of Medical Licensure to propose legislative language on the issue of certification of respiratory therapists.

Bob M. DeWeese, MD, KMA President-Elect, reported on his service as a member of the Advisory Committee to the Peerview, Inc., Board of Directors, and the Board appointed a Peerview Oversight Committee to implement Resolution B (1987). It was noted that other ad hoc committees had been appointed to implement Resolution P (1987), regarding the KMA Election Process, and Substitute Resolution G (1987), on professional liability insurors.

The Board accepted the report of a committee that had investigated a complaint received following the election of the Eleventh District Trustee during the September 16 meeting of the KMA House of Delegates.

A Judicial Council statement regarding physician administrative pressures under cost containment plans was reviewed, and the Board directed that a summary be published in the KMA *Journal*.

James B. Holloway, Jr, MD, Medical Director, Department of Medicaid Services, made a slide presentation regarding the current operation of the Medicaid Program, and staff provided an update on developments in the Medicare Program, including the issue of MAAC determinations.

It was reported that for the second year in a row HCFA intended to release data on hospital mortality rates. Concerns were expressed that the mortality rate data prediction is flawed, that the data would be misleading to consumers, and that mortality is a crude measure of quality.

The Board reviewed a recommendation of the KMA Committee on Medical Insurance and Prepayment Plans for the members' health insurance plan, and voted to retain the current High Option Plan; renew the Low Option Plan with Assurance Plus; and not offer Option 2000. It was further reported that the Committee did not oppose Diagnostic Guidelines in the manner BCBS planned to use them, and was studying proposed changes in UCR Guidelines developed by KMA and BCBS in 1968.

In other reports, it was noted that KMA now has 5,292 members, and that Articles of Incorporation have been drafted for the McDowell Foundation. It was also reported that the Hospital Medical Staff Section had determined that Resolution R, "Inappropriate Requirements for Hospital Staff Membership" (1987), could not be implemented as written, and the Resolution was referred back to HMSS for further consideration.

The Board endorsed Executive Committee recommendations that KMA recognize the existence of a nursing shortage, and directed the Committee to Investigate Changing Trends in Medicine to address the problem.

The next meeting of the Board of Trustees was scheduled for April 20-21, 1988.



Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities.



Pamela H. Potter, Ashland, President of the Auxiliary to KMA.



S. Randolph Scheen, MD, Secretary-Treasurer of KMA.

KMA Physicians Attend AMA Interim Meeting

KMA officers attending the AMA interim meeting in Atlanta, December 6–9, were asked to consider and vote on numerous issues. Actions taken by the House included:

—Seeking legislative means to "eliminate unfair fee distortions" created by the Current Maximum Allowable Actual Charge (MAAC) System. The MAAC System determines the amount a physician can raise charges by comparing his charge for a procedure with Medicare's prevailing charge ceiling for the physician's community.

—Adopting a measure to make certain any payment schedule used as Medicare payment methods are "uniformly and consistently applied to all services rendered by physicians and all specialties, and that the AMA strongly oppose Medicare schedules of allowances or RVs for certain specialties or subsets of services."

—Adopting a proposal to work with Medicare's PRO organizations rather than attempt to repeal the PRO system. In the reference committee, it was suggested that if PROs were abolished a harsher system would take its place.

—Challenging PROs and the Health Care Financing Administration (HCFA) to focus on high quality medical care that reflects community standards of care.

The House also adopted a report on AIDS encouraging increased education in the US. Steps to achieve this include:

—Nationally coordinated educational efforts aimed at specific population segments encouraging national coordination and tracking of all major AIDS health education and prevention activities; encouraging the federal government to increase funding for prevention and education and to take a stronger leadership role in ensuring interagency cooperation.

The AMA also acted on measures dealing with decisions to forego life-sustaining treatment:

—MDs should remain committed to sustaining life regardless of age, disability, or handicap, except in circumstances where efforts to prolong life would be inhumane.

—Patients should always be resuscitated except when such treatment would not be in accord with their desires or best interest.

—DNR decisions should reflect the patient's choice. If he or she is incompetent, the choice should be made by the patient's family or legal representative. In their absence, the order can be initiated by an MD, "when circumstances indicate that resuscitation might not be in the patient's best interest."

KMA Delegates attending the meeting were: Fred C. Rainey, MD, Elizabethtown; Kenneth P. Crawford, MD, Louisville; Donald C. Barton, MD, Corbin; Russell L. Travis, MD, Lexington.

Alternate Delegates were: Wally O. Montgomery, MD, Paducah; Robert R. Goodin, MD, Louisville; Harold L. Bushey, MD, Barbourville; Carl Cooper, Jr, MD, Bedford.

Other guests included: Nelson B. Rue, MD, KMA Vice President, Bowling Green; William B. Monnig, MD, KMA Board Chairman, Erlanger; Joseph E. Kutz, MD, JCMS President-Elect, Louisville; Larry Griffin, MD, JCMS Chairman, Louisville; Donald J. Swikert, MD, Delegate, Young Physician Section, Florence; Vaughn Payne, MD, Delegate AMA-RPS, Louisville.



(L to R) Alternate Delegates Harold L. Bushey, MD, Barbourville, and Wally O. Montgomery, MD, Paducah, review the issues with KMA Vice President Nelson B. Rue, MD, Bowling Green, and Jefferson County Medical Society President-Elect Joseph E. Kutz, MD, Louisville.



Seated front to back are KMA Delegates Russell L. Travis, MD, Lexington, and Kenneth P. Crawford, MD, Louisville, with Alternate Delegate Carl Cooper, Jr, MD, Bedford.



KMA Delegates Fred C. Rainey, MD, Elizabethtown (L), and Donald C. Barton, MD, Corbin (R), are seated with Alternate Delegate Robert R. Goodin, MD, Louisville.

AWARD NOMINATION

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☐ **Distinguished Service Award (Physician)**

☐ **KMA Award (Lay Person)**

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Military: _____

Membership in Professional Organizations: _____

Membership in Civic Organizations: _____

Honors and Awards: _____

(Describe nominees qualifications and other pertinent information which the Awards Committee may consider in making its decision).

Name of Person or Group Submitting Nomination: _____

Address: _____

Phone: (Home) _____

(Office) _____

Mail to: KMA, 3532 Ephraim McDowell Dr, Louisville, KY 40205, Attn: Awards Committee

Awards Nominations

The KMA Awards Committee is accepting nominations for the two highest awards the Association presents. The Distinguished Service Award is presented annually to a member of the Association based on the following criteria:

Contributions to organized medicine (including membership in county society, attendance of county and state meetings, service on committees, leadership as an officer, etc.)
Individual medical service
Community health, education and civic betterment
Medical research

The nominee may qualify on any one or all combinations of these points. Reasons for the nominations should be clearly stated.

The Kentucky Medical Association Award is presented to an outstanding lay person in Kentucky each year in honor of his or her outstanding accomplishments in the field of public health and/or medical care.

The Awards Committee will have the responsibility to choose recipients of the KMA Distinguished Service Award and the Kentucky Medical Association Award. Any county society or individual member may suggest nominees to the committee.

The awards are presented at the President's Luncheon during the annual meeting.

National Library of Medicine

One of America's best kept and most valuable secrets, is the National Library of Medicine (NLM). The Library houses the largest and most comprehensive collection of medical literature in the world. Yet little is known about the Library by the public and the health care community.

To increase visibility and support for the Library, the Friends of the NLM, a new nonprofit organization, is beginning a public service advertisement campaign in scientific and medical publications. The ads point out that health professionals have the world's most complete medical database at their fingertips by using the on-line services of the Library.

"The National Library of Medicine is not simply a vast collection of dusty old books," commented Edwin C. Whitehead, Chairman of the Friends. "The Library plays an active role in improving health care worldwide and providing answers to day to day medical problems."

NLM In Action

** In Detroit, a boy bitten by a poisonous snake is rushed to Sinai Hospital. Since the boy suffers from a blood disorder, doctors hesitate to treat him with an antivenin which could make him worse. A hospital librarian uses his computer to tap into the MEDLINE database at the NLM in Bethesda, Maryland. Moments later information flashes on the screen which indicates that the antivenin will not help, but a blood transfusion will. The boy is saved.

** An Atlanta physician is faced with a dilemma. He has never before treated a patient complaining of "numb chin". The doctor turns to his personal computer to seek assistance. He types in the term "numb chin" to seek assistance. He types in the term "numb chin" and in seconds he receives life-saving information, which, in turn, provides a vital clue in his diagnosis of a form of lymphoma.

** A pediatrician in suburban St. Louis is notified that three boys have been struck by lightning while playing baseball. The physician has never treated lightning injuries before, so he queries MEDLINE. By the time the ambulance arrives with the boys, the doctor knows exactly what treatment to follow.

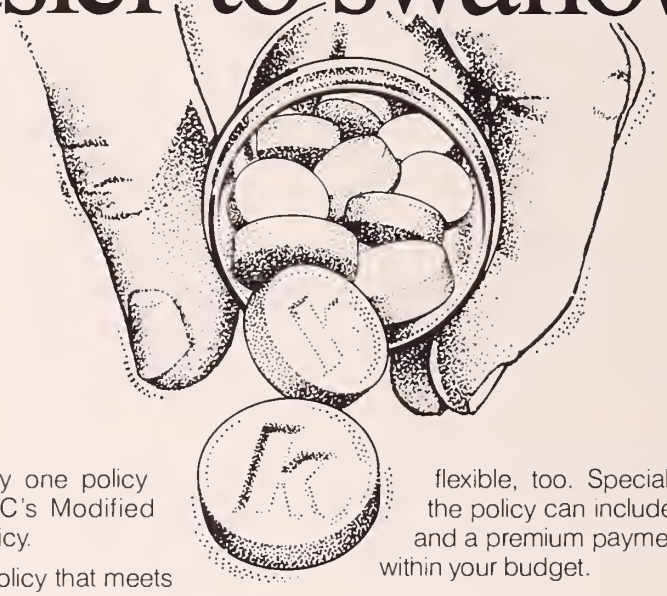
These real-life examples demonstrate the importance of the computerized MEDLARS databases which were developed by the National Library of Medicine. This online network of databases allows physicians and other health professionals to quickly cull through some six million references to journal articles, and to print out pertinent abstracts.

This vast focal point for medical and scientific information is available to health professionals around the world, as well as around the corner. Located on the National Institutes of Health (NIH) campus in Bethesda, Maryland, the Library serves as a hub of a network of seven regional medical libraries, 125 medical school libraries, and 4,000 hospitals and other medical libraries.

Users of the NLM range from health care professionals, to scientists, to pharmaceutical and medical equipment companies, to advertising executives. Originally established in 1836, the NLM includes more than 3.5 million books, journals, photographs, technical reports and audiovisual materials.

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Updates

Doctor Polk Assumes Leadership of Surgical Group

Hiram C. Polk, Jr, MD, Chairman of the Department of Surgery at the University of Louisville School of Medicine, has been elected president of the Southern Surgical Association.

A graduate of Harvard Medical School, Doctor Polk accomplished his surgical training at Barnes Hospital in St. Louis. He assumed the Chair of Surgery at U of L in 1971. Currently Doctor Polk is serving as Secretary of the American Surgical Association, President-Elect of the Louisville Surgical Society and Chief Editor of the *American Journal of Surgery.*

Maintain Contact With Your Legislator

Your legislators can generally be reached at home on weekends and in Frankfort on weekdays while the Kentucky General Assembly is in session. (Refer to the "Legislative Calendar" provided in the "KMA Legislative Handbook." Local addresses and phone numbers of Kentucky legislators are noted on the "Roster of Kentucky General Assembly Members," which is also a part of the Handbook.)

When the General Assembly is in session, you may call your legislator in Frankfort at the **Legislative Offices number...(502) 564-8167**, or call the **Legislative Message Center WATS Line...1-800-372-7181**, and leave a message for him. You may also check the status of a bill by calling the toll-free **Bill Status WATS Line...1-800-248-8132.** A toll-free **Calendar Line...1-800-633-9650**, is available where you may hear a taped calendar of committee meetings and the schedule for the Chambers to be in session. The calendar is updated daily.

Correspondence to your legislator while he or she is in Frankfort should be addressed as follows:

The Honorable John Smith
The Kentucky Senate (or Kentucky
House of Representatives)
State Capitol
Frankfort, KY 40601

Dear Senator Smith: or
Dear Representative Smith:

As you discuss a piece of legislation, be sure to identify the bill by its number and subject. State legislation is labeled **Senate Bill _____(SB); House Bill _____ (HB).** Legislation introduced in the form of a resolution in the Senate or House of Representatives, or both, is labeled **Senate Resolution _____(SR); House Resolution _____(HR). Be sure to properly and thoroughly identify the subject matter.**

If you have any questions or need assistance, contact the KMA office at 3532 Ephraim McDowell Drive, Louisville, KY 40205, phone: (502) 459-9790.

To assist KMA in coordinating its legislative effort, **please continue to send copies of your correspondence and any response to the State Legislative Activities Department of KMA; also send a brief note about personal or phone contacts and results.**

NEED A SPEAKER? . . .
for your next hospital staff,
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Contact the KMA Committee on Impaired Physicians.
(502) 459-9790

CME

1988

APRIL

8-9 "Corneal — Contact Lens Update 1988" — Radisson Plaza Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

8-9 "Sports Medicine for Physicians" — Hyatt Regency Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

9-10 "An Update in Allergy and Immunology" Thirteenth Annual Symposium — Lexington Marriott Resort, Lexington, KY. Contact John S. Hill, MD, 1725 Harrodsburg Rd, Lexington, KY 40504, (606) 276-1452.

15-16 "Aggressive Management of Diabetes and Obesity" — Hyatt Regency Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

15-16 First Annual Markey Cancer Center Symposium: Biologic Response Modifiers, Lexington, KY. For physicians and nurses. Contact: Hilary Wood, RN, MSN, (606) 257-4500.

22-23 "Therapeutic Advances in Acute Myocardial Infarction" — Hyatt Regency Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

25-May 6 The Johns Hopkins University School of Medicine 29th Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. In-Residence Course B is extremely concentrated lecture series with intensive laboratory studies and vital clinical experience at the Johns Hopkins Medical Institutions, Baltimore, MD. Contact: John K. Frost, MD, 604 Pathology Building, The Johns Hopkins Hospital, Baltimore, MD 21205.

29-30 "Contemporary Pediatrics for the Practicing Physician" — Hyatt Regency Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

MAY

9-13 "Diabetes In-Depth Training Workshop," Lexington, KY. 39 CEUs, $350 (daily rates also available). One week training program in diabetes, effective patient teaching, and setting up a diabetes program. Contact: Paula Gentry, 120 N Eagle Creek Dr, #321, Lexington, KY, (606) 263-5032.

22-27 "Nineteenth Family Medicine Review — Session II" — Hyatt Regency Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

JUNE

16-18 The 33rd Annual Great Smoky Mountain Pediatric Seminar at the Park Vista Hotel, Gatlinburg, TN. Sponsored by University of Tennessee Medical Center at Knoxville, College of Medicine, Department of Pediatrics and Knoxville Area Pediatric Society. Contact: Dr Sandra Loucks, University of Tennessee Medical Center, Dept of Pediatrics, 1924 Alcoa Hwy, Knoxville, TN 37920, (615) 544-9331.

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James H. Sammons, MD
Executive Vice President

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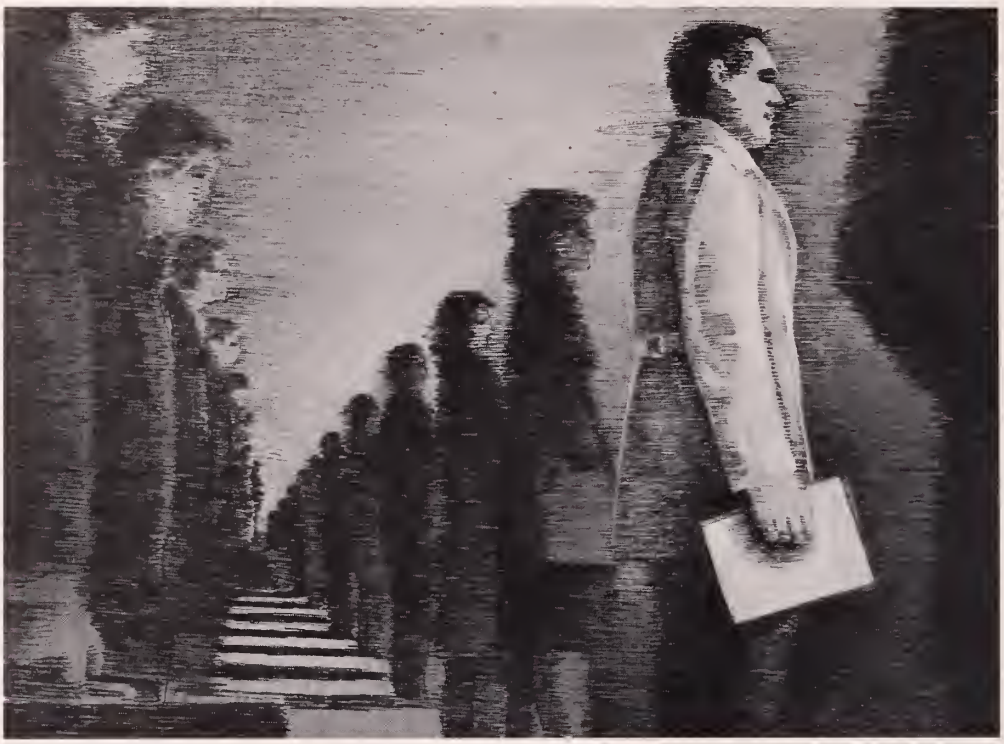
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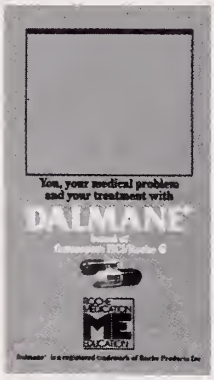
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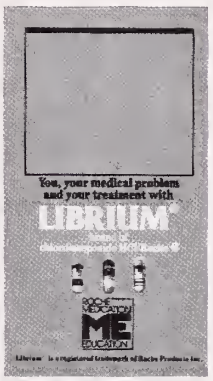
Complete the coupon and mail it to Professional Services Department, Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110.



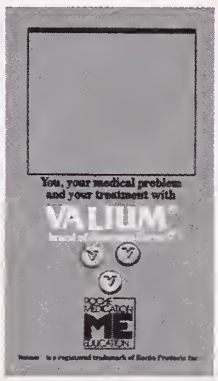
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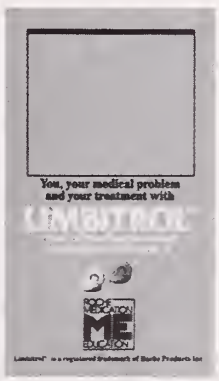
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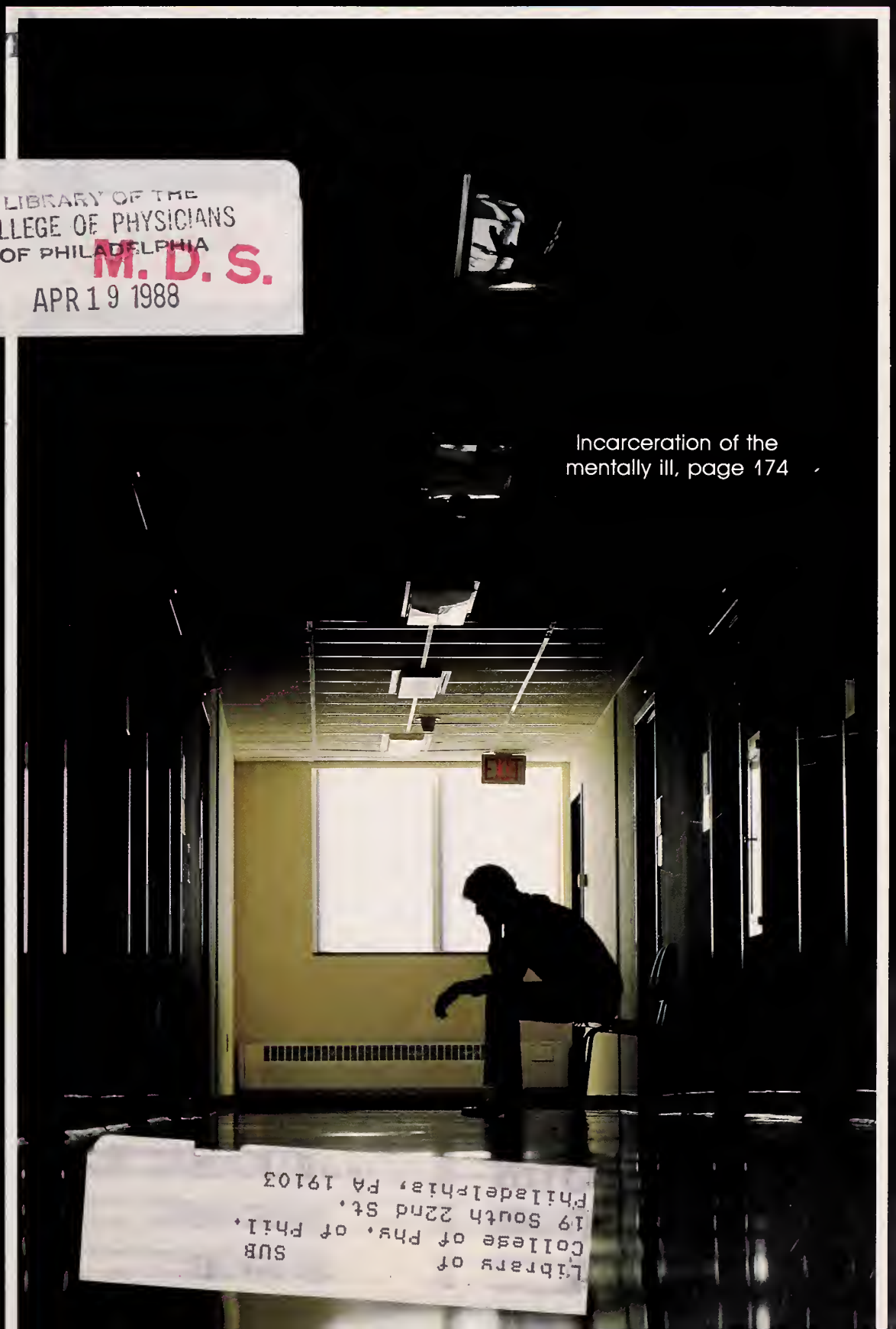
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Incarceration of the mentally ill, page 174

kma
VOL 86 NO. 4
APRIL 1988

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TABLE OF

CONTENTS

April 1988

Cover:
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SCIENTIFIC

Venous Air Embolism Associated with Removal of Central Venous Catheters
Jose M. Mendieta, MD; Thomas M. Roy, MD;
D. Marty Denny, MD; Miquel Ossorio, MD **169**

Incarceration of the Mentally Ill
Teresita Bacani-Oropilla, MD, and Danielle Turns, MD **174**

An Update on Hepatitis B Viral Disease (Grand Rounds)
Stephen I. Shedlofsky, MD **181**

EDITORIAL

Option Chirimimba **189**

SPECIAL ARTICLE

Physician Responsibility to Patients Under
Cost Containment Plans **191**

ASSOCIATION

Highlights of KMA Legislative Seminar **202**
The "New Look" for Your *Journal* of Your KMA **205**
KEMPAC Elects Officers for 1988 **206**
Annual Meeting Preview **207**
Application for Scientific Exhibits **208**

REGULAR FEATURES

President's Page **165**
Auxiliary **199**
CME **201**
Classified **209**
Information for Authors **173**

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April Buyer's Guide

Baptist Hospitals 210
Charleston Area Medical Center 187
Classified 209
Elcomp Systems, Inc. 166
Humana Heart Institute 168
Humana Hospitals 201
KMA Insurance Agency, Inc. 164, 190
KMIC 200
KMIC Investment Company 210
KMIC Leasing Company 160
Kentucky Air National Guard 197
Key Pharmaceuticals 197-198
Eli Lilly and Company 211
Medical Protective Company 167
PIE Mutual Insurance Company 176
Palisades Pharmaceuticals 198
Roche Laboratories 213-214
Skycare, Inc. 209
U.S. Army 188
University of Louisville
School of Medicine 210
Wyeth-Ayerst Laboratories 177-180



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PRESIDENT'S PAGE



The shortage of qualified nurses in the Commonwealth of Kentucky is rapidly reaching crisis proportions. The "Changing Trends in Medicine Committee" of the Kentucky Medical Association has been asked to join forces with the Kentucky Hospital Association Task Force for Allied Health and Nursing, the Multi-Disciplinary Task Force to Address the Shortage of Nurses in Kentucky, and the Kentucky Association of Health Care Facilities Committee to assess and address this common concern. Two such meetings have already been held.

The causes of this shortage are not simple and did not occur overnight. In the interest of cost containment, staffing has been cut to barest minimums. The patients now hospitalized are sicker when admitted and require more, not less, in-house care. They are an older population as well and not able to do much self care. Met with medical staff complaints, the feeling of being unable to meet patients' needs, and pressure from hospital administrators, nurses are experiencing unprecedented stress in their work place. This is driving many of our most dedicated and best trained nurses out of the hospital into physicians' offices, home health care agencies, insurance companies, and industry, as well as to drug companies. The practice of using RNs on a part-time, p.r.n. basis with no benefits package, shift hours, holiday hours, and a pay-scale generally lower than jobs for persons with comparable education, have added to the stress-burnout syndrome. These must be considered the major contributing factors. Hardest hit have been the critical care areas. Larger hospitals with larger salaries, flexible hours, bonuses and bounties for recruiters are luring nurses from smaller hospitals. These vacancies are difficult to fill. It cannot be denied as well that the real or perceived chance of exposure to the AIDS virus and the moral dilemma felt by health care personnel in general concerning care of these unfortunate patients is an issue. We as physicians cannot consider ourselves as removed from this crisis.

Treatment of our fellow nursing professionals is too often unprofessional. This complaint is as common as those concerning pay and benefits. They call us for questions or orders and are often treated rudely with anger and, all too often, profanity. If indeed by 1990, as is predicted, there is a 300,000-plus national shortage of qualified nurses, what will happen to our patients, our practice, our hospitals?

The saddest commentary of all is that our good nursing school candidates are going into other fields. Quality of applicants is down on the average. Many qualified applicants are applying for and being accepted into medical schools. Some colleges are actively recruiting nursing students, just as some hospitals are hiring full-time nurse recruiters.

How can we, as organized medicine, be part of the solution instead of part of the problem? Certainly, the dialogue with these health care task forces will help assess the problems and their causes, and hopefully find some solutions. These won't occur overnight. Legislators may also need to address this crisis.

In the meantime we should treat our nursing staff as fellow professionals and urge hospital administrators to re-evaluate their pay and benefits package. We should encourage the bright young "candy-striper" to consider nursing as a career. The situation will get better because it must. In an age of technology and medical care never before imagined, surely our patients must not suffer because of lack of nursing care. High tech and high touch must work together for our patients and our health care system.

Nelson B. Rue, Jr, MD
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Venous Air Embolism Associated with Removal of Central Venous Catheters

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Catheterization of the central veins has become routine in most hospitals because of its utility in the care of the critically ill or malnourished patient. Widespread acceptance of its use for fluid resuscitation, hemodynamic monitoring, and parenteral hyperalimentation means that most physicians will at some time care for a patient with a central venous catheter. Of the reported preventable complications of central venous catheter placement and subsequent use, venous air embolism is associated with the most significant morbidity and mortality. The precautions necessary to prevent inadvertent air entry during central venous puncture are well known to most clinicians. Likewise, it is accepted practice in the daily care of the patient with a central venous catheter to be sure that intravenous tubing connections are secure, thus avoiding venous air embolism. It is less widely appreciated that significant air entry may also occur during the removal of the catheter. We present a case of venous air embolism associated with removal of a pulmonary artery catheter and present a review of the diagnosis and treatment of venous air embolism.

Introduction

Central venous catheterization has become a common practice in the modern management of our more seriously ill patients. The most common indications for this procedure include measurement of central venous pressure, Swan-Ganz catheterization, fluid resuscitation, and parenteral hyperalimentation. Catheter insertion, in experienced hands, is relatively safe with an acceptable risk/benefit ratio. Those physicians who place central catheters are well aware of the potential complication of venous air embolism occurring during the insertion process and employ various measures to prevent its occurrence. Likewise, most physicians and nurses exercise great vigilance to ensure that intravenous lines attached to central venous catheters remain securely attached, thus avoiding inadvertent air entry into the lesser circulation. It is less widely appreciated, however, that venous air embolism can occur upon catheter removal, causing significant morbidity and mortality.

Since many physicians and nurses who do not routinely insert central venous catheters may find themselves in a situation that requires them to remove such a device, we felt that a discussion of the potential complication of venous air embolism would be in order. We would like to demonstrate the importance of our topic with a case report and review the suggested treatment of venous air embolism should it occur.

Case Report

The patient, a 32-year-old female, was admitted to the hospital after ingesting 5 gm of imipramine, 60 mg of lorazepam, and an undetermined amount of alcohol in an apparent suicide attempt. She was comatose at the time of arrival in the Emergency Department, was intubated, and was placed on mechanical ventilatory support. She was hypotensive with a systolic blood pressure of 70 mm Hg. A pulmonary artery catheter was placed via the right subclavian vein for hemodynamic monitoring and vigorous fluid resuscitation. Dopamine infusion at 45 mcg/kg/hr was used to supplement crystalloid fluid resuscitation at 800cc/hr. Sodium bicarbonate was administered parenterally to effect alkalinization as part of the protocol for tricyclic antidepressant overdose. Oxygenation and ventilation were well maintained during her initial hospital course, but necessitated continued mechanical ventilation. The electrocardiogram showed some minor tachycardia, but there were no arrhythmias, conduction delays, or QT prolongations. The initial chest radiographs were interpreted as normal, with good position of the pulmonary artery catheter and the endotracheal tube. The serum toxicology screen confirmed the presence of imipramine (1658 ng/ml) and ethyl alcohol (0.18 mg%). The remainder of her laboratory studies were within the normal limits.

With the supportive care rendered, the patient became hemodynamically stable and gradually regained her normal mental status. On the sixth hospital day, the patient had

sufficiently improved to allow discontinuance of mechanical ventilation and removal of the endotracheal tube. The patient was alert and oriented and was encouraged to sit up in a reclining chair at the bedside.

Later that same day, it was decided to remove the central venous catheter. This was performed in a sterile fashion with the patient in a semi-upright position in the reclining chair at the bedside. Approximately one to two minutes post-removal of the catheter, the patient was noted to be in acute respiratory distress with tachypnea and central cyanosis. She was immediately placed back onto the bed in the supine position. Cardiovascular collapse ensued with loss of blood pressure, loss of consciousness, and decerebrate posturing. Cardiopulmonary resuscitation with advanced cardiac life support measures was immediately instituted. Re-intubation was accomplished without difficulty and oxygen was delivered at an FIO2 of 100% in conjunction with manual and mechanical ventilation. Adequate oxygenation was maintained. The patient was placed in the left lateral decubitus head down position as venous air embolism was considered in the differential diagnosis. After 45 minutes of intense resuscitation, during which time the patient appeared to be in electromechanical disassociation, blood pressure and effective cardiac function were restored. The patient, however, remained unresponsive and at the time of this report has not improved from her vegetative state.

Echocardiogram was performed immediately after the patient was restabilized, but failed to show any air in the right ventricle. Chest radiograph demonstrated that a right-sided pneumothorax had occurred during closed chest massage and a chest tube was subsequently inserted. No air was demonstrated in the mediastinum or pulmonary artery outflow tract. The electrocardiogram demonstrated supraventricular tachycardia and questionable subendocardial and subepicardial injury pattern. Subsequent cardiac enzyme analysis was negative for the CPK-MB fraction. Computed tomography of the head was performed within 36 hours of the cardiac arrest and was normal. EEG was consistent with diffuse encephalopathy. At approximately 48 hours post-arrest, the patient's chest film demonstrated a normal heart size with bilateral pulmonary edema. Perfusion lung scan was performed four days after the acute event and was interpreted as "indeterminate probability of pulmonary embolus." Venogram of the right upper extremity was normal and failed to show evidence of thrombus formation.

The sudden deterioration of the respiratory, cardiac, and central nervous systems immediately after removal of the right subclavian vein catheter suggests cause and effect and is clinically consistent with that described for venous air embolism. Failure to demonstrate air in the right ventricle or pulmonary artery outflow tract is not uncommon in survivors of venous air embolism. A thrombotic pulmonary embolism from the catheter or the subclavian vein is a less likely explanation of the emergency in this individual. A fibrin embolus significant enough to cause cardiovascular collapse in a young person would be expected to occlude at least 40% to 50% of the pulmonary circulation. An embolus of this magnitude would not be expected to show a nondescript perfusion scan, normal chest parenchyma on chest radiograph post-code, nor a totally normal venogram of the right upper extremity. The presence of electromechanical disassociation also argues strongly for the pathophysiology of air embolism.

Discussion

The use of central venous catheterization in the care of the seriously ill or malnourished patient is a widely accepted facet of modern medicine. The insertion of a central venous line is performed with an acceptable complication rate by experienced physicians from a variety of disciplines.[1] Of the immediate complications associated with catheter insertion, venous air embolism (VAE) is the most fatal, and great caution is generally exercised during the procedure to avoid inadvertent air entry into the venous circulation. After the catheter is successfully placed, venous air entry is prevented during its use by continuous attention to the intravenous tubing connections, secure dressings, and use of in-line air filters. Widespread adherence to these precautions limits the occurrence of fatal venous air embolism, although reports still surface when faulty equipment is used[2] or if intravenous lines become accidentally disconnected.[3]

It is less widely appreciated that precautions must be taken against venous air entry when the catheter is being removed. Venous air embolism occurring at the time of or shortly after catheter removal has been described in the literature [4,5,6] and is illustrated by our case report.

Venous air entry associated with catheter removal is thought to occur along the catheter tract during the brief interval between the withdrawal of the catheter and sealing of the tract. The degree of risk of air entry in this situation is influenced by several factors. Obviously the longer the catheter has been in place the greater the tendency for the tract to seal slowly. This is especially important in catheters used for parenteral hyperalimentation. VAE has been reported, however, after removal of catheters in place for only three days[5] and this has been attributed to a very short tract from the skin to the point of venous puncture. Hypovolemic patients and patients whose catheters are removed when they are in an upright or semi-upright position are at greater risk due to the increase in negative intrathoracic pressure which is normally transmitted to the large veins leading to the heart. In addition, coughing may tend to separate soft tissues along the catheter tract and the forceful inspiration immediately following a cough may facilitate the entry of air.[4]

To protect the patient from inadvertent air entry and potentially fatal venous air embolism, we would encourage that a central venous catheter be removed with the patient in the supine or slight Trendelenberg position and the entry site be immediately covered with an occlusive dressing. In the high risk patient described above, this dressing should be left in place for 24 hours to allow the subcutaneous tract to close.[5]

Should VAE occur, the consequences depend primarily upon the volume and rate of air entry which are influenced by the site of venous puncture, the patient's position, and the patient's underlying cardiovascular status. Despite intensive research, the exact amount of air required to cause symptoms and/or death in humans is controversial. Some investigators feel that VAE is more common than realized, is generally well tolerated, and escapes attention because the quantity of air entry is small, causing signs and symptoms which are nonspecific.[7] This concept is supported by the observation that the documented occurrence of VAE during neurosurgery in the sitting position is approximately 25%, although symptomatic air embolism is rare.[8]

Larger volumes of air cause significant cardiovascular and central nervous system problems. Based on animal studies, volumes of 1-2 ml/kg can be fatal, although smaller volumes may be lethal in the critically ill patient.[9] The rate at which the air enters the circulation is of great importance. The observation has been made that the slower the air entry, the larger the lethal dose required. In clinical practice, it is estimated that air entering the venous circulation at 20 ml/sec will be associated with symptoms and 75 to 100 ml/sec with death.[10] While this degree of air entry may at first glance seem unlikely, Flanagan et al[11] have shown that a 100 ml of air per second can occur through 14 gauge needle with a pressure gradient of only 5 cm H_20. With rapid air entry death has been recorded with volumes of air of 100 ml and less.

When the air has entered a systemic vein, it travels to the right ventricle via the vena cava. Here it sets up an "air lock" which impedes the ability of the ventricle to pump effectively, reducing the blood flow to the pulmonary vasculature and the left heart. Some air moves into the pulmonary arterioles where it causes occlusion. Venous pressures rise greatly, while systemic blood pressure falls as a result of reduced cardiac output. Reduced cerebral blood flow may lead to syncope, seizures, or coma. To compound the catastrophic consequences, the increased venous pressures may promote introduction of air into the arterial circulation through pre-existing pulmonary arteriovenous communications or through potentially patent foramen ovales which are normally closed due to interatrial pressure differences. Minute amounts of air in the arterial circulation are poorly tolerated and are associated with CNS and coronary artery lesions.

The diagnosis of VAE is essentially a clinical one and should be considered when a patient with a central venous catheter in place, or just removed, develops alterations in respiratory, cardiovascular, or central nervous system function. Virtually all patients with significant air embolism will have a sudden onset of respiratory difficulty

manifested variably as tachypnea, dyspnea, chest pain, and/or hypoxemia. Others may develop cardiovascular collapse, seizure, or coma.

The physical examination may show cyanosis, tachypnea, neurologic deficits and hypotension. A wide variety of heart sounds have been described with VAE, but it is the churning "mill wheel" murmur that is most frequently described on auscultation of the chest. It should be noted, however, that the presence of this murmur is a late occurrence, is transient, and is dependent on a large amount of air being present in the right ventricle and pulmonary outflow tract.

Ancillary studies are rarely helpful in the acute situation but have been described. The EKG can show ischemia, bradycardia, conduction disturbance, and right heart strain.[12] This limits its effectiveness in the differential diagnosis of fibrin pulmonary embolism and myocardial infarction which are more common possibilities. Air-blood fluid levels have been reported on chest radiographs,[7,13] but generally require an upright film which is impractical and ill-advised in the crisis situation. Air has been found on CT scan of the head when performed shortly after the onset of neurologic changes.[14,15] Perfusion lung scans are abnormal during the acute event but return to normal in survivors after about 48 hours.[16] This is generally a more rapid resolution than seen with fibrin pulmonary emboli. The echocardiogram is very sensitive for air in the ventricle and may prove to be a helpful aid in diagnosis in the nonsurgical patient.

Immediate treatment of the patient with VAE involves placing the patient in the left lateral decubitus position with the head down (Durant's position). This position will allow the air to occupy the superior apex of the right ventricle and allow blood to pass through the inferiorly located pulmonary outflow tract into the lungs maintaining the preload of the left heart.[17] Oxygen is administered at 100% to promote reabsorption of air from the pulmonary circulation. Aspiration of air from the right ventricle by a catheter placed in this chamber will also shorten the symptomatic period. Hyperbaric oxygen therapy, if readily available, will both decrease the size of the embolus and promote its absorption. This mode of treatment is especially helpful when air has entered the arterial circulation and has caused CNS changes. Closed chest compression to augment cardiac output is advised by some, but this is difficult to accomplish in the left lateral decubitus position and probably adds little to the other supportive measures mentioned above.[18]

With the use of these therapeutic maneuvers, the mortality of VAE associated with central venous catheters ranges from 30% to 45%.[19] Unfortunately, approximately one-half of the survivors will have some form of residual neurologic deficit due to either cerebral hypoxia, hypotension, or cerebral air embolism.[10] Also, the clinician must be aware that many survivors will develop ARDS 24 to 48 hours after the acute event. This is due to the effect of the air trapped in the pulmonary arterioles on leukocyte production and release of toxic oxygen metabolites and is independent of hypotension and treatment modalities during the acute event.[20]

Since virtually all cases of VAE can be prevented, we hope that our discussion will raise the consciousness of our medical community to the potential occurrence of venous air entry during catheter removal and promote the use of simple precautions when these devices are discontinued.

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Incarceration of the Mentally Ill: A Question of Legality

Teresita Bacani-Oropilla, MD
Danielle Turns, MD

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This paper portrays the poignancy of mental illness. Because dangerousness and violence cannot be predicted, the illustrative vignette also demonstrates the quandary that psychiatrists face in recommending whether a patient with a history of violence should or should not be incarcerated. Laws protect the rights of persons not to be held against their will. Kentucky's laws are specific on criteria for involuntary hospitalization. Treatment plans have to be individualized for each patient.

He struck terror in their hearts. Whenever he wrote them a letter, it caused a flurry of correspondence between two large metropolitan hospitals. Whenever he appeared at the perimeter of one of them, he was met by an escort of security guards.

He was really not formidable looking. A sick, middle-aged black man, he walked slowly, deliberately lifting one swollen leg after another. More often than not, he was out of breath. His sad eyes peered from puffy eyelids. He was gentle of manner and soft of voice.

In his youth, he had lost a son, which heralded the onset of a mental illness from which he never fully recovered. This had brought him under the care of a psychiatric hospital in Indiana. It was his unshakable belief that he was connected by a transmitter to a black box that could control his life and health. One only had to aim the transmitter to his chest and he would have difficulty breathing, to his legs and he would have swelling, to his heart and it would fail. He repeatedly asked then, that the transmitter be disconnected to ease his suffering. One day, he went to the administrator and failing to have his request granted, shot the man in the head. He was prosecuted, found guilty, sentenced to a prison term, and released many years later. He moved south and fell under the catchment area of a Kentucky hospital.

The years had caught up with his health. He now lived alone, his previous family and friends having gone their separate ways. He kept close contact with his physicians, alternately being admitted to the medical or psychiatric wards.

He said he had learned his lesson. Never would he hurt anybody again. He was glad his victim did not die and had eventually gone back to work. Being incarcerated was something he wanted to avoid at all cost. Prison was an unhappy place to be. However, the belief that disconnecting the "transmitter" would cure his ills persisted. Many times he wrote the Indiana hospital begging for relief. Twice, unarmed, he paid them a visit to plead his cause. Both times, he was adequately guarded, escorted out, and referred back to Kentucky.

Discussion

The dilemma was whether this patient should remain free or not. If free, would he constitute a danger to others? If incarcerated, on what would it be based? The patient had already served his term for the crime he had committed. He could not be doubly jeopardized!

"If an insane person is a threat to the community, the court can order civil confinement — confinement of a person not accused of a crime."[2] However, this person had repeatedly avowed he would not hurt anyone, had not made any threats, did not have a particular person as his target, and the hospital concerned was in the next state. Predictions of dangerousness and violence are difficult to make, even among experienced professionals. In this case, dangerousness could not be proven nor negated.[3,4]

Besides, in a ruling on "Kenneth Donaldson, a self-supporting adult committed to the state hospital because of delusions, the 5th Circuit court in 1975 ruled that a state has no right to lock up a patient against his will and keep him indefinitely without treatment because he is mentally ill. A person who can survive in freedom by himself or with the willing help of family or friend, cannot be confined against his will unless he poses a serious threat to the safety of the community."[1,5] This patient was being aided by a cousin and despite his ill health, managed to come to his clinic appointments. He was surviving adequately outside of institutions.

Furthermore, Kentucky law[2] requires four prerequisites for involuntary commitment:
1. That the person is mentally ill.

2. That he represents a danger to himself or others.
3. That the person benefit from treatment.
4. That hospitalization is the least restrictive form of treatment.

If it could be proven that this patient fulfilled the first two criteria, he would not meet the last two. His delusions were fixed, hospitalization would not serve a purpose beyond restricting his movements.

Faced with this quandary, legal minds were consulted. They confirmed that the patient was not commitable. The only alternative was close observation of the patient by his doctors, anticipation of his agitated periods, and adequate communication and coordination between the two hospitals involved. The possibility of history repeating itself was thus averted in this imperfect manner for the next few years.

Conclusion

During one of his recent visits to the psychiatrist, the patient confided that he had given up hope that anyone would intervene to have the transmitter disconnected. He had become increasingly short of breath and thought that his end was near. If and when he died, would this doctor care to send him some yellow roses?

A few days after discharge from the medical wards, the patient died in his sleep. His quest for relief had ended. Among the floral offerings at his wake was a bouquet of yellow roses, a little token that if it had been possible, his other wish would have been granted.

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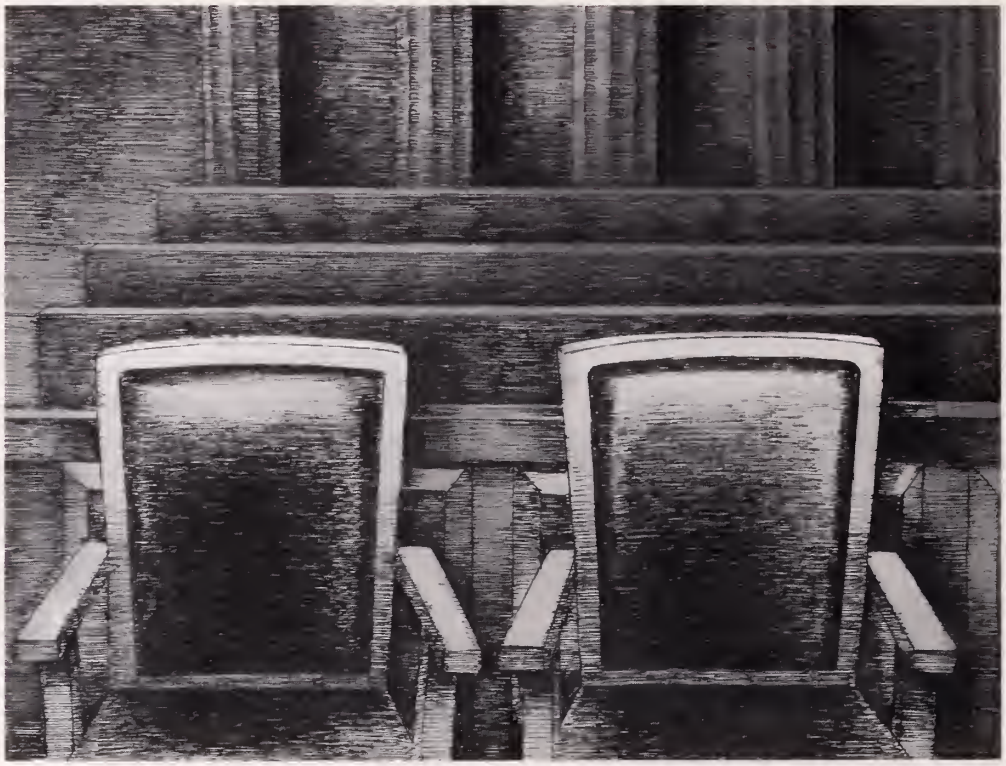
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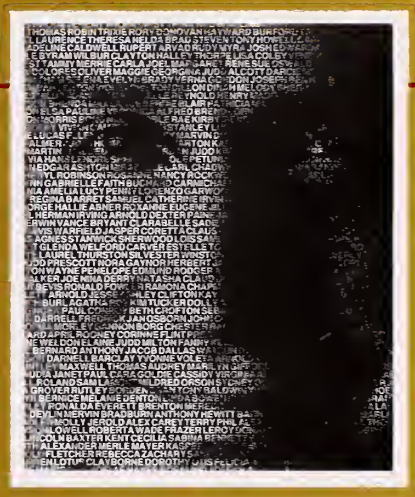
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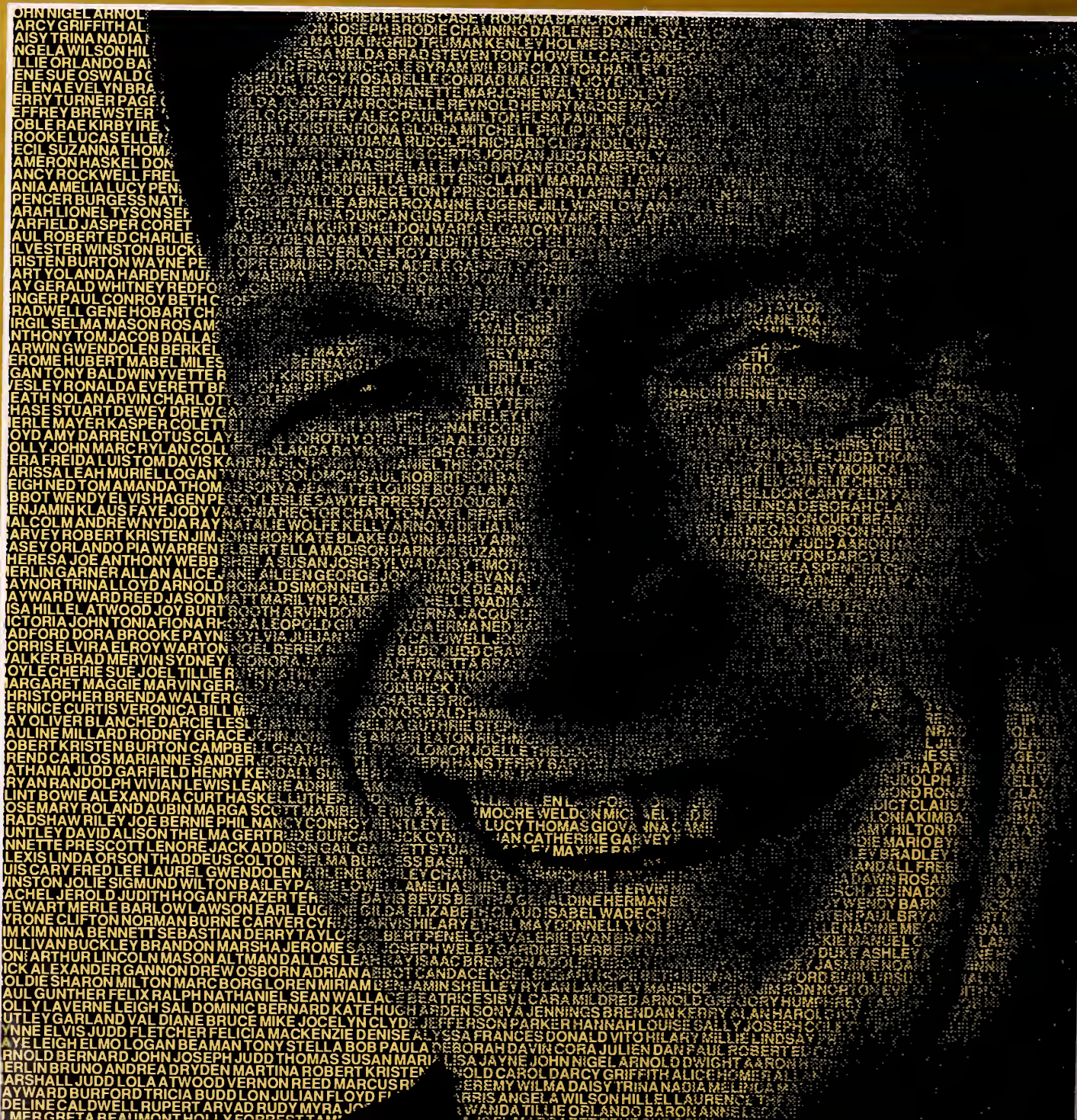
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In a recent survey, 4,120 participating physicians gave us their views[1] on INDERAL LA in the treatment of hypertension, angina and migraine.

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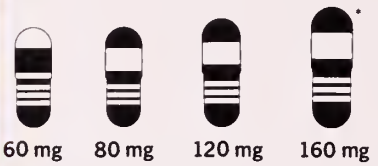
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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following *abrupt* discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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Reference:

1. Data on file, Ayerst Laboratories.

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An Update on Hepatitis B Viral Disease

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Much has been learned about the Hepatitis B virus (HBV) and its clinical manifestations in the last several years. Although it has been difficult for many health care workers to assimilate much of this important new information, a current understanding of HBV disease is required not only for the care of patients with acute and chronic hepatitis, but also for understanding proper HBV surveillance policies, vaccination procedures, and post-exposure prophylaxis. Furthermore, because HBV is responsible for the vast majority of the world's primary hepatocellular carcinoma and liver failure, especially where there are high endemic rates of neonatal HBV infection, prevention of maternal transmission through surveillance and vaccination has become a major goal. This review will first describe the structure of, mode(s) of infection for, and serologic responses to HBV, and then briefly discuss each of the major clinical situations in which HBV disease presents itself, highlighting the most important aspects of proper management.

Structure, Transmission, and Serologic Responses to the Hepatitis B Virus

HBV, whose presence was originally discovered as the "Australian Antigen" by Blumberg[1] in 1965, is a uniquely structured virus that infects only human liver cells[2] (see Fig 1). The complete virion is called the "Dane" particle and has a lipoprotein outer coat called HBsAg (hepatitis B surface antigen). HBsAg is markedly overproduced by infected liver cells so that most HBsAg found in serum is actually devoid of HBV DNA and can be "harvested" and used to prepare a safe vaccine (see below). Within the HBsAg coat is a protein complex called the hepatitis B core antigen which encases the viral DNA. From the core complex, another protein called HBeAg (hepatitis B "e" antigen) is released when host proteases partially degrade the virus.

All infected subjects develop antibodies to HBsAg, the core, and HBeAg.[3] However, during the acute infection, only IgM antibody to core (IgM-anti-HBc) can be readily detected and this antibody is used as a marker of acute infection. Antibodies against HBsAg and HBeAg also are produced, but if antibody excess exists, the antibodies might either prevent detection of their antigens or form immune complexes which can cause illnesses as polyarteritis nodosa or mixed cryoglobulinemia.[4]

Infection with HBV is contracted: (1) *by transfer of infected serum* (eg, addicts who share needles, needlestick victims in hospitals and laboratories, patients who receive blood products; (2) *during intimate sexual acts* (either homosexual or heterosexual); and (3) *by infected mothers who transmit the virus to their children in the neonatal period,* (not *in utero*), probably through breast milk, saliva, and serum exposures onto mucous membrane lesions.[2] HBV is NOT fecal-orally spread and non-intimate casual household contacts need not fear transmission but should avoid sharing items such as dinnerware and toothbrushes.

Once HBV is in the host serum, it is taken up by receptors on liver cells (which also recognize polymerized human albumin) and the HBV DNA is released. HBV DNA is unusual in that it is only partially double-stranded. This configuration apparently allows the DNA to become incorporated into host DNA with chronic infection (see below).

Infected liver cells are not actually damaged by HBV infection. In fact, it is the host immune defenses that attack the infected cells, thereby causing a "hepatitis." In the vast majority of adult cases (~95%), all the infected liver cells are destroyed and the subject recovers from either a mild subclinical infection or a clinically apparent acute hepatitis.[3] Neonates and young children, whose immune defenses are not as strong, are much more likely to develop a chronic HBV carrier state.

If HBV infected cells are not eliminated, two types of chronic HBV infection develop[5] (see Fig 2). In so-called *"chronic B hepatitis,"* the HBV is in a "replicative phase" and DNA remains free within the nucleus and stimulates a host immune response causing an ongoing hepatitis. There is serum transaminase elevation and histological evidence of inflammation (chronic persistent or chronic active hepatitis). In most such patients, progression to cirrhosis and liver failure is likely.

In many chronically infected subjects, however, the HBV enters a "quiescent" or "nonreplicative" state in which the HBV DNA becomes incorporated into the host DNA.[5] The host immune response is not stimulated and clinical hepatitis is absent. This is termed the *"asymptomatic 'healthy' carrier"* state. The infected cells still produce HBsAg which is seen in cytoplasm as a "ground glass" appearance, but free nuclear HBV DNA is usually not present. Infectious virions are not produced in any quantity, so that anti-HBe is detectable. Unfortunately, what is not yet clear is whether asymptomatic carriers are in a permanent "good" state of infection or whether they are merely delaying some of the sequelae of chronic HBV (ie, cirrhosis and hepatoma). It does appear that quiescent HBV can be "reactivated" and it is likely that a spectrum exists between severe chronic B hepatitis and the asymptomatic carrier state.

Finally, no discussion of HBV would be complete without a description of the *Delta virus*, a defective liver cell-specific RNA virus that utilizes the excess "empty" HBsAg to travel in serum.[6] Delta is transmitted in the same way as the HBV and can either be part of the acute HBV infection or superinfect someone with chronic HBV. It has been clearly shown that whenever Delta infection occurs, the clinical hepatitis is much worse both acutely and chronically. A recent epidemic of Delta in the Yucpa Indians in Venezuela had an 18% mortality from fulminant hepatitis. Most cases were superinfections of Delta in chronic HBV carriers. Whereas Delta is common in drug addicts in the United States and Europe, it is uncommon in homosexuals and is uncommon in the Far East.

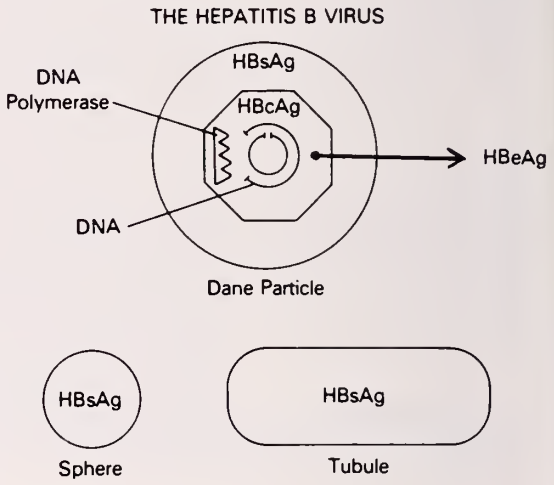


Figure 1

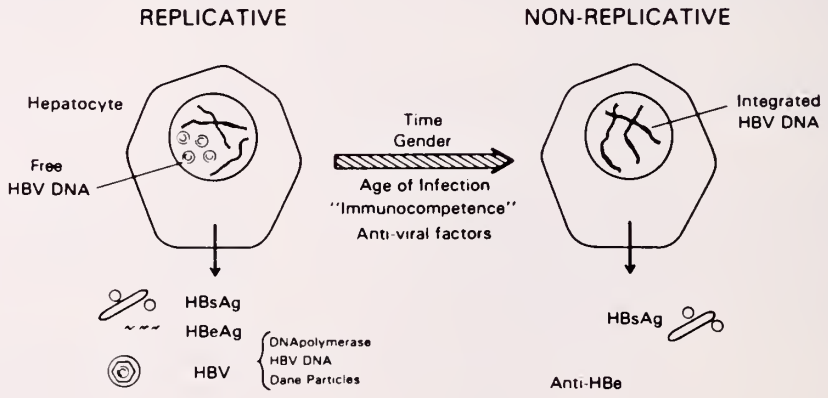


Figure 2

TABLE 1
PATTERNS OF SEROLOGIC MARKERS IN ACUTE VIRAL HEPATITIS

IgM Anti-HAV	HBsAg	IgM Anti-HBc	Intrepretation
+	—	—	Acute hepatitis A
+	+	—	Acute hepatitis A (chronic HBsAg carrier)
—	+	+	Acute hepatitis B
—	—	+	Acute hepatitis B
—	+	—	Chronic hepatitis B
—	—	—	Non-A, non-B hepatitis

Presentations of HBV Infection and Issues of Prophylaxis.

1. *Acute B Hepatitis.* A patient who presents with jaundice, RUQ pain, fever, dark urine, and has elevated transaminases on laboratory testing may have an acute HBV infection, especially if there is a history of IV drug use, exposure to blood products, or intimate association with a chronic or acute HBV hepatitis patient. To diagnose HBV the three serologic studies shown in Table I should be ordered for proper interpretation. It is not acceptable to order just an HBsAg.

Although most cases of HBV infection are subclinical, in adults at least 25% are clinically manifest as hepatitis.[3] Of these cases $<1\%$ progress to fulminant hepatitis (ie, worsening of jaundice with mental dysfunction progressing to coma). HBV is the most common cause of fulminant hepatitis and there is evidence that if the patient loses detectable HBsAg, there is a better chance of survival. Currently there is no specific therapy for acute HBV infection and supportive measures with avoiding further hepatotoxic agents is all that can be offered.

2. *Asymptomatic "healthy" HBV Carrier.* Often a subject will be referred because a blood bank or "routine" screening as part of an employment physical will find a positive HBsAg. This otherwise healthy subject is rightfully concerned about what this means. Proper evaluation includes a careful exposure history, a physical examination, and laboratory studies including a repeat HBsAg, IgM anti-HBc, HBeAg, anti-HBe, and liver function tests. If transaminases are elevated and the IgM anti-HBc is positive, this could be part of an acute infection and it is reasonable to wait three to six months and repeat the studies. If transaminases are (persistently) elevated with a negative IgM anti-HBc, then the patient should have a liver biopsy to determine the extent of liver damage and rule out other causes of liver disease. Subjects with totally normal liver function tests do not need to be biopsied.

A patient with a positive HBeAg is much more likely to be infective than if he were anti-HBe positive. However, HBe status is purely for advising the patient and his family about risks and cannot dispel all future worry about HBV sequelae. It is reasonable to repeat HBsAg testing annually and, because early single hepatomas can often be surgically removed, six month or annual α-fetoprotein determinations are indicated.

3. *Chronic B Hepatitis.* Because $\sim$1-3% of acute HBV infections in adults and an unknown percentage of neonatally infected subjects develop a chronic inflammatory process, HBV is a common cause of chronic active hepatitis. These patients typically present with symptoms of fatigue, RUQ pain, and may have stigmata of chronic liver disease including ascites. A percutaneous liver biopsy should be performed if coagulation status permits and there is no ascites.

Currently no specific therapy for chronic HBV exists and *steroids are contraindicated.* Although experimental antiviral agents (eg, ARA-AMP, interferons) are being tested, there have been no breakthroughs so far. Reports have appeared showing that short courses of steroids with abrupt withdrawal and addition of antivirals can help "deacti-

TABLE 2
WOMEN FOR WHOM PRENATAL HBsAg SCREENING IS RECOMMENDED

1. Women of Asian, Pacific Island, or Alaskan Eskimo descent, whether immigrant or U.S.-born.
2. Women born in Haiti or Sub-Saharan Africa.

and
Women with histories of:

3. Acute or chronic liver disease.
4. Work or treatment in a hemodialysis unit.
5. Work or residence in an institution for the mentally retarded.
6. Rejection as a blood donor.
7. Blood transfusion on repeated occasions.
8. Frequent occupational exposure to blood in medico-dental settings.
9. Household contact with an HBV carrier or hemodialysis patient.
10. Multiple episodes of venereal disease.
11. Percutaneous use of illicit drugs.

vate'' the HBV; but this therapy has also been associated with worsening liver failure and must be considered dangerous.[7] Avoidance of hepatotoxins (EtOH, acetaminophen) and management of sequelae as they occur are all that can be offered. Although some endstage liver patients have undergone liver transplantation, evidence of active viral replication is a contraindication since the new liver is likely to become infected.

4. *Who are candidates for HBV vaccine?* Heptavax® Vaccine was released in 1980 after it was shown to be safe and efficacious in preventing HBV transmission in high-risk homosexual populations in New York.[8] This vaccine is prepared by harvesting HBsAg from chronic carriers, purifying the HBsAg and then subjecting it to a rigorous process which inactivates all live viruses (including the AIDS virus) yet doesn't destroy immunogenicity. Initial fear that the vaccine might contain the AIDS virus discouraged its use. But clearly the reason why vaccination has not become more popular is cost ($120 for all three injections). A newly released vaccine prepared by recombinant DNA technology (Recombivax®) is unfortunately no cheaper and long-term efficacy has not yet been established.

Anyone who is exposed to blood products in their work (ie, most health care workers and laboratory personnel) should be vaccinated, as well as persons in high risk groups (eg, drug addicts, male homosexuals, institutionalized mentally retarded, and spouses of chronic HBV carriers). A major use is the prevention of neonatal HBV transmission (see below).

For adults, the vaccine (20μg or 1mL) is injected IM at 0, 1, & 6 months. Buttocks injections should be avoided and the vaccine should never be frozen. Renal failure patients require a two-fold dose plus testing for a response (anti-HBs). If a subject is in a high-risk group, it is cost-effective to first check HBsAg status before starting vaccination which might not be needed. Most vaccinees need not be tested for a response. Booster injections after five to ten years are not currently recommended.

5. *Neonatal transmission and prenatal screening.* It is recommended that a selected group of high risk mothers (see Table 2) be screened for HBsAg and, if positive, their infants be given both passive immunization with hyperimmune B globulin (HBIG) and vaccinated (see Table 3). Testing for HBsAg and anti-HBs is recommended at one year. HBsAg positive mothers should probably NOT breast feed if bottle feeding is possible.

The above therapy will prevent >95% of maternal transmission. Although prevention of neonatal HBV infection is most important in countries with high endemic rates of chronic HBV infection, it is still an important consideration in Western countries. In fact, a recent study from Miami[9] concluded that it would be cost effective to screen ALL EXPECTANT MOTHERS for HBsAg, rather than just the groups listed in Table 2.

6. *Needlestick and mucous membrane*

TABLE 3
HEPATITIS B VIRUS POSTEXPOSURE RECOMMENDATIONS

	HBIG		VACCINE	
Exposure	Dose	Recommended Timing	Dose	Recommended Timing
Perinatal	0.5 ml IM	Within 12 hours of birth	0.5 ml (10 μg) IM	Within 7 days*; repeat at 1 & 6 mos
Percutaneous	0.06 ml/kg IM or 5 ml for adults	Single dose within 24 hours	1.0 ml (20 μg) IM†	Within 7 days*; repeat at 1 & 6 mos
	or§			
	0.06 ml/kg IM or 5 ml for adults	Within 24 hours; repeat at 1 mo	—	—
Sexual	0.06 ml/kg IM or 5 ml for adults	Within 14 days of sexual contact	¶	—

* The first dose can be given the same time as the HBIG dose but at a separate site.
† For persons under 10 years of age, use 0.5 ml (10 μg).
§ For those who choose not to receive HB vaccine.
¶ Vaccine is recommended for homosexually active males and for regular sexual contacts of chronic HBV carriers.

exposures. Although most people who are exposed in the workplace should be vaccinated, this ideal has not yet been achieved and many health care and laboratory personnel are still at risk from contaminated blood. When an exposure occurs from a source that is known to be positive or is likely to be positive (eg, a hepatitis patient), the victim should be given HBIG within 24h and vaccination begun in the opposite arm within 7d (see Table 3). Baseline HBsAg and anti-HBs studies should be drawn before the HBIG to determine whether subsequent vaccination is necessary. If the source of the needlestick is unknown and not very likely to be contaminated, the baseline HBsAg and anti-HBs studies can be drawn, the victim immediately given standard immune serum globulin (0.06mL/Kg, which has a good titer of anti-HBs), and vaccination begun. If the victim has been vaccinated, it is a good idea to check an anti-HBs just to make sure protection exists and in the interim give standard immune globulin. In every case, follow-up at one month for review of studies and repeat vaccination and/or LFT testing should occur.

7. *Post-exposure prophylaxis after sexual exposures.* When either heterosexual or homosexual partners of chronic carriers or newly discovered HBV infected patients present within 14d of their exposure, the official recommendation is to give the rather expensive HBIG as a single dose and then decide on vaccination depending on whether further exposure is likely (see Table 3). Because spouses of chronic carriers usually already have markers of HBV, they usually do not need post-exposure prophylaxis. However, checking HBsAg and anti-HBs status is indicated to see if vaccination is needed.

8. *Hepatocellular Carcinoma.* Once it became clear that hepatomas were caused by chronic HBV infection[10] measures to prevent HBV transmission took on greater importance. All patients with chronic HBV infections should have regular (every 6-12 months) α-fetoprotein determinations and any increase should be reconfirmed and followed by imaging studies. Although many such patients have severe cirrhosis and are not candidates for partial resection of a solitary nodule, candidates can be long term survivors.

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Health and Safety Tip From the American Medical Association

MARKERS LISTED TO IDENTIFY ALCOHOLICS

How can you tell that a regular, heavy drinker has crossed over the line and become an alcoholic, who no longer can control his or her drinking?

The American Medical Association in its Manual on Alcoholism points to some markers to help identify the alcoholic.

1. Increasing consumption of alcohol, with frequent, perhaps unintended, episodes of intoxication.

2. Drinking to handle problems or relieve symptoms.

3. Obvious preoccupation with alcohol and the frequent need to have a drink.

4. Surreptitious drinking or gulping of drinks.

5. Tendency toward making alibis and weak excuses for drinking.

6. Refusal to concede what is obviously excessive consumption and expressing annoyance when the subject is mentioned.

7. Frequent absenteeism from the job, especially following weekends and holidays.

8. Repeated changes in jobs, particularly if to successively lower levels, or employment in a capacity beneath ability, education and background.

9. Shabby appearance, poor hygiene, and behavior and social adjustment inconsistent with previous levels or expectations.

10. Persistent vague physical complaints without apparent cause, particularly insomnia, stomach upsets, headaches, loss of appetite.

11. Multiple contacts with the health care system with disorders that are alcohol caused or related.

12. Persistent marital and family problems, perhaps with multiple marriages.

13. History of arrests for drunkenness or drunken driving.

Submitted by the KMA Impaired Physicians' Committee

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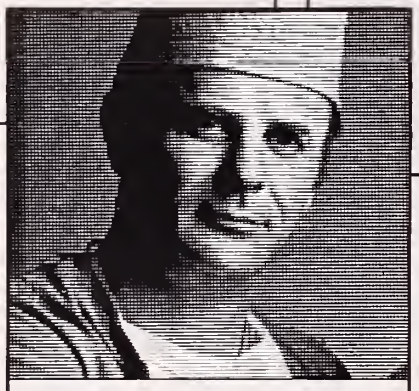
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"Option Chirimimba"

Harare, Zimbabwe (AP)

— A man who had attacked members of his family with an ax was shackled in a hut for six years by his father, a newspaper reported yesterday.

Peter Chirimimba, 47, was chained up in 1982 by his 70-year-old father, Munetsi, in the Rushinga district of northeastern Zimbabwe, The Herald reported. His father told The Herald that treatment by a traditional healer hadn't curbed his son's violent outbursts.

— Reprinted from the ***Courier-Journal****, February 5, 1988*

Small thoughts, wisps in the wind, may stimulate great ideas and associations, and it has been said by a light-duty thinker that the one who interprets and utilizes an idea is as creative as the one who generates the idea in the first place. While this is palpably untrue, let me claim this latter virtue long enough to remark on an item, dated Zimbabwe, Africa, which appeared in the first section of a recent newspaper. Though the one who is charged with avoiding white spaces in newspaper columns must have seen this item only as a filler, it just may contain the germinal truth of a plan that will save our nation billions of dollars in health care costs.

The news was that Chirimimba, a man age 47, had attacked members of his family with an ax and was therefore shackled in a hut for six years by his father, Munetsi, age 70.

Implied in this brief case report is the fact that astute clinical observation by the family spotted Chirimimba's misbehavior as a product of illness rather than simple wickedness. And when one therapeutic approach (traditional healers) failed the family fell back on basics and solved the problem in their own way.

We in the First World, moving down rapidly toward Third World status, have much to learn about medical care from these countries we had once sought to help by sending physicians, ministers and teachers. In no area are we in the United States more needful than in the appropriate distribution of health care resources. We are indebted, for example, to the Chinese for the concept of barefoot doctors, who are well meaning, lightly trained and lightly qualified care givers. Everything indicates that the United States is now producing these in abundance. But even this level of sophistication may be too expensive for a faltering capitalistic state since barefoot doctors charge about the same as those of us with shoes and there are more of them all the time. Accordingly, we are told that we must tailor our medical care concepts to the resources available — run out of cloth, shorten the pants.

Visualize, if you will, Chirimimba's care in the United States even ten years ago. He would have been taken to a psychiatric hospital, there to be cared for by physicians and nurses, plied with potent medicines, even food. He would likely have had to stay for a month and have become well, but it would have cost a pretty penny merely to get him to give up the ax and return to his job and his family.

I mailed this clipping about Chirimimba to my friend, Jimmy Jack Snopes, a short-order cook until he got his new position as supervisor of case managers for Inequitable Care Minus. It turned out that he had already seen the item and it had been a great inspiration to him. He telephoned, "When I read that I realized what a tremendous job we have of re-educating you docs and the American people. Those Zimbabwe folks understand how to do it. America can't afford to take care of sick people and still turn a profit for the insurers." He began to get excited and his voice rose.

"Surely," I responded, "you don't mean that, Mr. Snopes. People may stop buying insurance if the insurers won't pay for medical care . . ."

He interrupted, "You're kidding yourself, boy. It's either us or the Feds and you know how *they* pay. This is a new age. And if you docs don't get with it you'll be left out. It would be good for some of you to have to work for a change!"

I was cautious not to offend him. "Well, how do you feel this approach would work in the United States?"

"We've been having some meetings about it. First, we'll ask EMS to go see if its a real ax he's swinging. If it is, we'll send a technician from our office here and he'll fix a stout anchor into the floor of a back room, preferably upstairs. Then we'll custom fit the chain. Now listen up, boy — here's the beauty part. We will have solved this problem for the family and we'll have spent less than 50 bucks for the whole caper. The hospital would have shaken us down for $10,000." He paused to savor the logic of his approach. "Now we've got to deal with the DRG problem. We don't like 'em any better'n you guys do. The real answer is to keep people out of the hospital in the first place. That way there ain't no DRGs. We've got a task force now to deal with every specialty in medicine. 'Back to the home,' is what we say. We've known for a long time that practically every baby will get born if you sawbones just get out of the way. We've got a physician's assistant now who tells us she can do hysterectomies in the home. We'll probably need the floor anchor and the chain for that one too."

"That certainly does sound exciting and innovative."

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Physician Responsibility to Patients Under Cost Containment Plans

Charles J. Cronan IV

The author is an attorney with the law firm of Stites & Harbison, 600 W Main St, Louisville, Kentucky 40202.

This opinion was rendered by Legal Counsel at the request of the Judicial Council of the Kentucky Medical Association and addresses the physician's responsibility to resist administrative or financial pressure by alternative delivery systems affecting the level of care given to patients. This is published at the request of the Board of Trustees.

The Problem

"Cost Containment" as an ideal is difficult to oppose. Theoretically, it is to be achieved by improved technology and greater efficiency (through planning, monitoring, etc) in the delivery of care. With this increased efficiency, the theory goes that the cost of health care should be reduced while the level of quality remains unchanged. A major flaw in the "ideal" is that it is predicted on the assumption that physicians, across the board, have squandered health care resources. While that may be true in limited cases, the greater probability is that the American public has assumed entitlement to the highest level of care without regard to cost. Certainly, *cost of care* has not been the focus of legal and ethical standards of physician conduct on which liability for medical malpractice has been based in the past.

Today, physicians are faced with an increasing number of financial considerations and incentives which have potential to affect their medical judgment and the level of care rendered to their patients. Given these financial considerations and incentives, have the rules of liability changed? Only one reported case, discussed later, addresses the question head on, and the answer is "no."

Some of the Incentives

A first step in avoiding liability due to improper influence of financial pressure on medical judgment is recognizing the sources of financial pressure and the potential conflict they create. Some of the risks posed by cost containment aspects of "managed care" include the following:

DRGs: Because payment is fixed and and made on a prospective basis, the hospital's incentive to discharge the patient using less than the DRG allowance is clear. To the extent DRGs represent the historical cost of treating "average" patients with a particular diagnosis, cost containment may result in delivering less than "average" care. To the extent that continued staff privileges are dependent upon "efficient" or "economical" delivery of services, financial pressure on the hospital may be passed along to the physician.

Capitation Payments: A number of delivery systems compensate primary care physicians on the basis of capitations; that is, a fixed dollar amount per member, per month, regardless of the amount of care required. Under this system, the physician profits to the extent that the total cost of caring for those patients is less than the capitation payments. In essence, capitations are to the physician what DRGs are to the hospital.

"Withholds" or "Reserves": A number of HMOs and managed-care plans withhold a portion of the physician's fee and return it only in the event the plan is "profitable." In some instances, only those physicians deemed "efficient utilizers" share in distribution of the reserve accounts. Generally, "efficient utilization" means rendering care at a cost less than the premiums paid by or on behalf of the patients.

Preadmission Certification and Administrative Aspects of Managed Care: One of the most subtle, but potentially most dangerous, aspects of HMOs and other forms of alternative delivery is the requirement that physicians assume increased administrative burdens in addition to caring for the health of the patient and, at the same time, are also being asked to reduce their fees.

Another subtle form of pressure exerted by many HMOs is the obligation of the physician to exercise independent judgment on the one hand but, on the other hand, to be denied fees if retrospective peer review determines services not to have been medically necessary.

The Physician's Legal and Ethical Obligations

Traditional Legal Principles

A physician's legal obligation to his or her patient is measured by a "standard of care." Generally, that standard is defined as the care which a reasonably prudent physician of the same specialty would render to a

patient under the same or similar circumstances as those in question. Traditionally, the "circumstances" might include such things as the availability of medical resources in a particular locale. Generally, these resources have included such things as the availability of a CAT scan, certain physical facilities, or highly trained specialists.

Traditionally, these "circumstances" have not included cost considerations. Undoubtedly, however, as cost control measures continue to play an increasingly important role in health care, courts may include cost considerations as one of the "circumstances" bearing on physician liability. Good arguments can be made that economies do affect the standard of care expected of a physician. However, while the law may change, it has not yet done so.

Cost Containment Case Law

The only case specifically to have addressed the effect of cost containment measures on the standard of care is the November 1986 decision in *Wickline v. State of California.*

In *Wickline,* the California Court of Appeals addressed the legal responsibility of a third-party payor (California Medi-Cal) for injury to a patient which allegedly resulted from prospective utilization review and its effect on the treating physician's medical judgment. Under prospective review, the patient's discharge date was established by Medi-Cal at the time of hospital admission.

Mrs. Wickline was a married woman in her mid-forties with a limited education. She had been treated conservatively by her family physician for problems associated with her back and legs. Failing to respond, she was seen in consultation by a vascular surgeon who diagnosed her condition as Leriche's Syndrome correctable only by surgery.

Mrs. Wickline was eligible for medical assistance benefits under California's Medicaid program (Medi-Cal). Application for approval of the surgical procedure was made by the family physician, and Medi-Cal authorized ten days of hospitalization.

On the day after admission, Wickline underwent surgery involving the implantation of an artificial artery. Later that day, she experienced circulatory problems in her right leg. The vascular surgeon concluded that a clot had formed, necessitating a second surgery during which the incision in her right groin was reopened, the clot was removed, and the graft was resewn. Wickline's recovery period following the two operations was "stormy" with incidents of spasm, extreme pain, and hallucinations. Six days post-operative, the patient underwent a lumbar sympathectomy. Four days later, on the initially scheduled discharge date, the vascular surgeon concluded that the patient required an additional eight days of hospitalization. Accordingly, the necessary forms were completed by the hospital and an application for extension was submitted to Medi-Cal.

Wickline's application for extension was reviewed by a registered nurse employed by Medi-Cal. The nurse felt she could not approve the requested extension under Medi-Cal guidelines. She telephoned a surgeon employed by Medi-Cal as a consultant. After speaking with the nurse on the telephone, Medi-Cal's consulting surgeon denied the request for an eight-day extension, but approved an additional four days beyond the originally scheduled discharge. On the discharge date, both the family physician and the vascular surgeon wrote discharge orders without any further attempts to obtain an extension.

The testimony of Wickline's vascular surgeon is key to an understanding of the case. In executing the discharge orders, his belief that Medi-Cal consultants had the state's interest more in mind than the patient's welfare influenced his decision not to request a second extension of Wickline's hospital stay. Moreover, he felt that Medi-Cal had the power to tell him, as the treating doctor, when a patient must be discharged from the hospital. Despite these beliefs, the vascular surgeon also said that if, in his medical judgment, Wickline's condition had been "critical" at the time of discharge, he would have made further efforts to keep her in the hospital even if denied authority by Medi-Cal and even if he had to pay for it himself! Thus, on the one hand, the surgeon testified to his belief that Medi-Cal controlled the discharge decision but, on the other hand, did not believe the patient's condition was sufficiently serious at the time of discharge to make further protest. Unfettered by the Medi-Cal discharge date, he would have

kept the patient in the hospital under observation for several more days. Thus, while he would have done otherwise, he was not in a good position to criticize Medi-Cal's decision.

Mrs. Wickline returned home where, over the course of a little more than a week, she suffered both a loss of circulation and wound infection in the leg, which ultimately was amputated at mid-thigh.

In retrospect, the vascular surgeon expressed an opinion that, had Wickline remained in the hospital, the deteriorating condition of her leg would have been observed and corrected.

Mrs. Wickline filed suit against Medi-Cal but did not sue either her treating physicians or the hospital because she had extremely good rapport with them and felt they had done all they could. The jury found against Medi-Cal and awarded Mrs. Wickline $500,000 for the loss of her leg. Medi-Cal appealed.

The California Court of Appeals reversed the decision of the trial Court, noting that a determination of negligence is not measured by precise standards, but always relates to some circumstances of time, place, and person. In addressing the question of whether the treating physician or the health care payor bears responsibility for allowing a patient to be discharged from the hospital, experts on both sides of the case agreed that, under the standard of care then in effect, it was for the patient's treating physician to decide the medically necessary course of treatment. It was also the physician's responsibility to determine whether or not acute care hospitalization was required and for how long. Finally, the experts agreed that the patient's physician was in a better position than Medi-Cal to determine the appropriate length of stay. Thus, the decision to discharge was viewed as the responsibility of the patient's treating physician.

Undoubtedly, the California Court of Appeals was influenced by the testimony of the treating physicians that, at the time of discharge, they did not consider the patient's condition to be "critical," nor did they protest or appeal Medi-Cal's denial of the requested extension. In reaching its result, the Court was careful to point out that it was not holding third-party payors immune from liability under all circumstances. To the contrary, the Court expressed a view that third-party payors can be held legally accountable when medically inappropriate decisions result from implementation of cost containment mechanisms such as when a physician's appeal on behalf of the patient might be ignored or unreasonably disregarded, or where unqualified administrators were called on to make medical judgments. Although Medi-Cal was observed to play a part in the scenario because it was the source of funds to pay for the treatment, its input regarding length of stay did not override the medical judgment of the treating physicians because, when the time arrived, the physicians neither made any protest nor brought any new information to Medi-Cal's attention.

As to physician responsibility under the facts of this particular case and the cost containment mechanism of a prospective length of stay determination, the court stated:

> . . . The physician who complies without protest with the limitations imposed by a third party payor, when his medical judgement dictates otherwise, cannot avoid his ultimate responsibility for his patient's care. He cannot point to the health care payor as the liability scapegoat when the consequences of his own determinative medical decisions go sour. [663]

The California Medical Association (CMA) submitted a brief in the *Wickline* case as an aid to the Court. Although it took no position on the facts of the particular case, CMA did offer the Court a description of the dilemma facing physicians:

> CMA recognizes the responsibility of the medical profession to cooperate in controlling health care costs; however, CMA has an obligation to describe patient risks which badly constructed or maintained systems present. CMA is also concerned that physicians not be placed between the proverbial rock and hard place. A patient who is injured when care which should have been provided is not provided will recover from someone. If the third party payor imposing these controls is permitted to avoid liability by maintaining the fiction that the mechanisms have only fiscal consequences, so that patient care is solely the physician's responsibility, the physician becomes the insurer. If rationing malfunctions, the physician who complies with the program is liable to the patient. If the physician does not comply, the physician is punished or faces responsibility for incurring unauthorized costs.

As previously described in the summary of facts, the California Court of Appeals did not absolve third-party payors from liability under all circumstances, nor did it hold that physicians would be responsible under all circumstances. In simplest terms, the message of the *Wickline* case is that physicians are expected to continue exercising their best medical judgment in the interest of their patients, regardless of the influence of third-party payors, and are expected to object when their judgment is disregarded.

The California Supreme Court has agreed to review the *Wickline* case, but has not yet issued an opinion.

With the exception of the California Court of Appeals, no court in Kentucky or elsewhere has issued an opinion addressing liability issues similar to those raised in the *Wickline* case. However, because of the proliferation of alternative delivery systems, and because "cost containment" mechanisms so seriously impact the delivery of medical care, it is probable that hospitals, third-party payors and alternate delivery systems will be held accountable for their role in causing adverse consequences to the patient.

Evidence of growing sensitivity to financial considerations adversely impacting patient care is found in the 1986 Comprehensive Budget Reconciliation Act's prohibition against a hospital or risk-sharing organization's knowingly making a payment, directly or indirectly, to a physician as an inducement to reduce or limit services to persons entitled to Medicare or Medicaid assistance. Further, in the same Act passed by Congress in October 1986, the Secretary of Health and Human Services has been ordered to make a report not later than January 1, 1988, concerning incentive arrangements offered by HMOs and competitive medical plans to physicians. Among other things, the Secretary is to evaluate the potential of various incentive arrangements to "pressure improperly physicians to reduce or limit services in a medically inappropriate manner . . ." and to recommend which incentives may be used to encourage efficiency without "substantial potential for adverse effect on quality."

Ethical Considerations

The American Medical Association's Principles of Medical Ethics have been adopted as part of the Kentucky Medical Licensure Act. Those principles, as interpreted in the "Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association — 1986," are considered authoritative and are followed by the Kentucky Board of Medical Licensure.

Among those principles which address the physician's responsibility under situations posing potential conflicts of interest — including cost containment programs — are the following:

> 2.03 ALLOCATION OF HEALTH RESOURCES. A physician has a duty to do all that he can for the benefit of his individual patient. To expect a physician when treating a patient to make rationing decisions based on governmental or other external priorities in the allocation of scarce health resources creates an undesirable conflict with the primary responsibility of the physician to his patient.
>
> 2.09 COSTS. While physicians should be conscious of costs and not provide or prescribe unnecessary services or ancillary facilities, social policy expects that concern for the care the patient receives will be the physician's first consideration. This does not preclude the physician, individually, or through medical organizations, from participating in policy-making with respect to social issues affecting health care.
>
> 4.04 ECONOMIC INCENTIVES AND LEVELS OF CARE . . . In a situation where the economic interests of the hospital are in conflict with patient welfare, patient welfare takes priority.
>
> 8.03 CONFLICTS OF INTEREST: GUIDELINES . . . [5] When a physician's commercial interest conflicts so greatly with the patient's interest as to be incompatible, the physician should make alternative arrangements for the care of the patient.
>
> 8.03 CONTRACTUAL RELATIONSHIPS. The contractual relationships that physicians assume when they enter prepaid group practice plans are varied . . . Physicians should not be subjected to lay interference in professional medical matters and their primary responsibility should be to the patients they serve.
>
> 8.12 REFERRAL OF PATIENTS — DISCLOSURE OF LIMITATIONS. When a physician agrees to provide treatment, he thereby enters into a contractual relationship and assumes an ethical obligation to treat the patient to the best of his ability. PPO and

> HMO contracts generally restrict the participating physician's scope of referral to medical specialists, diagnostic laboratories, and hospitals that have contractual arrangements with the PPO or HMO. Some plans also restrict the circumstances under which referrals may be made to contracting medical specialists. If the PPO or HMO does not permit referral to a noncontracting medical specialist or to a diagnostic or treatment facility when the physician believes that the patient's condition requires such services, the physician should so inform the patient so that the patient may decide whether to accept the outside referral at his own expense or confine himself to services available within the PPO or HMO. In determining whether treatment or diagnosis requires referral to outside specialty services, the physician should be guided by standards of good medical practice.
>
> 9.06 FREE CHOICE . . . In choosing to subscribe to a health maintenance or service organization or in choosing or accepting treatment at a particular hospital, the patient is thereby accepting limitations upon free choice of medical services.
>
> 9.10 PEER REVIEW . . . Utilization committees, and other forms of peer review have been long established by organized medicine to scrutinize physicians' professional conduct. At least to some extent, each of these types of peer review can be said to impinge upon the absolute professional freedom of physicians. They are, nonetheless, recognized and accepted. They are necessary. They balance the physician's right to exercise his medical judgment freely with his obligation to do so wisely and temperately.

Clearly, the tenor of these ethical principles is that while physicians may participate in managed care programs, a physician's exercise of medical judgment in the best interest of the patient should not be compromised.

Recommended Policy to Avoid Liability

Neither law nor medicine can be practiced in "cookbook" style. Decisions have to be made on the basis of the particular facts of each case. However, the following general guidelines will minimize the risk of physician liability created by various cost containment and managed-care plans:

1. Be alert to potential conflicts and, where possible, avoid them. Where they cannot be avoided, be guided by the ethical principle that a physician must act in the best interest of the patient. Exercise your best, independent medical judgment, recognizing that the health consequences of your decision are primary and that economic considerations are secondary. The court in the *Wickline* case summed up the resolution of these conflicting priorities of cost containment as follows:

> Its [cost containment] purpose is to promote the well recognized public interest in controlling health care costs by reducing unnecessary services while still intending to assure that appropriate medical and hospital services are provided to the patient in need. However, such a cost containment strategy creates new and added pressures on the quality assurance portion of the utilization review mechanism. The stakes, the risks at issue, are much higher when a prospective cost containment review process is utilized than when a retrospective review process is used.
>
> A mistaken conclusion about medical necessity following retrospective review will result in wrongful withholding of payment. An erroneous decision in a prospective review process, on the other hand, in practical consequence, results in the withholding of necessary care, potentially leading to a patient's permanent disability or death.

2. Act as an advocate for the patient. Tell the patient and the plan what you believe to be medically necessary. For example, in the *Wickline* case, Medi-Cal's guidelines for length of stay may have been based on an "average patient." However, the treating physician may have been in a position to point out that discharge based on the "average patient" should not apply since *this* patient's level of education, home environment, number of children, etc, substantially increased the risk of post-operative complications.

3. When you believe that the application of a cost-containment measure materially affects the health of your patient, protest the plan's decision. If unsuccessful, inform the patient of your opinion, the steps taken on the patient's behalf, and the plan's decision. Recommend the proper course of action from a medical standpoint and make it clear that the *economic* decisions must be made either by the patient or by the plan. Follow up by documenting your efforts on behalf of the patient in the medical records. Where the risks of harm are particularly great, transmit your opinion and recommendation to the plan in writing.

4. Exercise caution when entering into "provider agreements" and other contractual relationships with third-party payors. On the one hand, you may be obligated to act as an "independent contractor" (one who exercises independent judgment in professional matters) but, on the other hand, must agree to abide by determinations of a utilization or peer review committee. Thus, the committee may be in a position to second guess your independent judgment and, finding a procedure not medically necessary, withhold payment. Given this potential conflict, inform yourself of the peer review procedures followed by a particular plan (Who sits on the committee? Can you personally appear? What are the appeal rights?). Contract only with those plans giving you a reasonable level of comfort that your independent judgment will be honored under retrospective review.

Conclusion

Because of the speed with which changes are being made in "traditional" methods of health care, formulating an opinion addressing the physician's responsibility to resist administrative or financial pressure from alternative delivery systems is like shooting at a moving target. While philosophical and social debates over the question of "Who pays, and for how much?" rage on, people quietly continue to need medical care and doctors called on for day-to-day decisions deserve guidance.

The bedrock of the physician-patient relationship is trust that the physician will act on behalf of the patient and without regard to extraneous financial pressures. Although changes in liability laws are likely to follow the evolution of medical delivery systems, a physician's best protection against liability continues to be insistence on the independent exercise of medical judgment in the best interest of the patient.

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INDICATIONS AND USAGE: BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

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3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose

Skin rash has been reported rarely

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity

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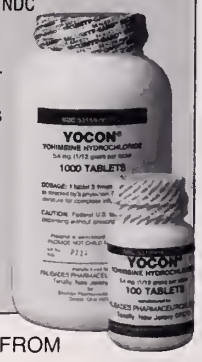
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

Adverse Reactions: Yohimbine readily penetrates the (CNS) and produces a complex pattern of responses in lower doses than required to produce peripheral a-adrenergic blockade. These include, anti-diuresis, a general picture of central excitation including elevation of blood pressure and heart rate, increased motor activity, irritability and tremor. Sweating, nausea and vomiting are common after parenteral administration of the drug.[1,2] Also dizziness, headache, skin flushing reported when used orally.[1,3]

Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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April marks a time of change for the Auxiliary. At the AKMA Convention held April 25-27, my term of office will end and Carol Franks (Mrs. Larry) will assume the Presidency. Although the Convention will bring to an end one very enjoyable phase of my personal involvement in AKMA, it is clear that our annual transfer of leadership marks neither an end nor a new beginning but merely a time of transition for the organization.

This year we have faced the same problems many voluntary organizations face today. We have turned these problems into opportunities for growth, and we can all be proud of our accomplishments this year.

AMA-ERF contributions continue to flow in from successful county fund-raising projects. A new AKMA fund raiser will be completed by Convention, and we are optimistic that our total contributions this year will exceed those of the past.

Auxiliaries across Kentucky continue to provide many successful health and community service projects. This year the AMA Auxiliary has focused on projects relating to Adolescent Health. Kentucky Auxiliaries have responded with programs on teen pregnancy, substance abuse, and AIDS education to name a few. The improved sharing of health projects information by county Auxiliaries has resulted in the spread of other successful health projects across the state.

I wish that I could report that our membership has grown by 10% this year, but I cannot. I am proud to report, however, that many of our counties have increased their membership totals. Each of these counties should be congratulated for the excellent job they have done in the area of membership development. Under the very capable direction of our State Membership Chairman, Esther Jansing (Mrs. C. William), special efforts have been made to improve communication with and to provide membership assistance to our smaller county Auxiliaries. The special recruitment challenges faced by Auxiliaries in large metropolitan areas have been addressed through workshops and visits from national representatives. Work has been done this year on the organization of new county Auxiliaries and, with the assistance of KMA, special emphasis has been placed on the recruitment of members-at-large. It is obvious that we still have a long way to go in our membership development efforts, but it is equally obvious that we are on the right track and moving in the right direction.

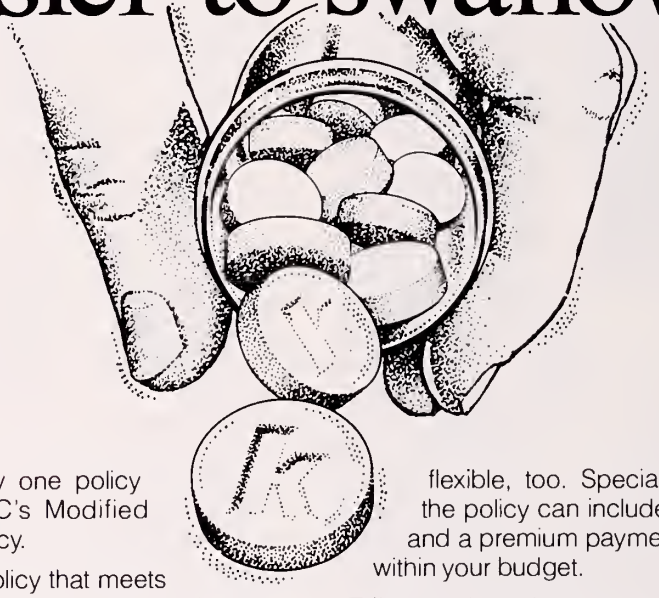
Legislation has been a special interest of Auxiliaries this year. The Fayette County Auxiliary participated in a statewide phone bank during the recent legislative session. A legislative alert system was organized through the County Auxiliaries. More than 60 Auxilians took advantage of the opportunity to express their opinions regarding pending legislation to their legislators during the Auxiliary's "Day at the Capitol."

I am indebted to each AKMA Board member and county leader for the tremendous job they have done this year. I am grateful to each member of AKMA for it is their participation and support that has made the Auxiliary strong. I appreciate very much the encouragement and support the Auxiliary has received from the leadership and staff of KMA as we have worked together to achieve our common goals.

When I began my term as President of the Auxiliary a year ago, I talked about turning our visions into realities. I complete my term knowing that we have reached some of our goals, and we have set the stage for the realization of others. Our accomplishments this year were based on a solid foundation built by the very capable Presidents, Board members, and county leaders who preceded us. We in turn have laid the foundation upon which future Auxiliary leaders can build. Through their efforts, today's visions will become tomorrow's realities.

Pamela H. Potter
AKMA President

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Sponsored by the Kentucky Medical Association.

April 8-9
Corneal — Contact Lens Update 1988 — Radisson Plaza Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

April 8-9
Sports Medicine for Physicians — Hyatt Regency Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

April 9-10
An Update in Allergy and Immunology — Thirteenth Annual Symposium — Lexington Marriott Resort, Lexington, KY. Contact: John S. Hill, MD, 1725 Harrodsburg Rd, Lexington, KY 40504, (606) 276-1452.

April 15-16
Aggressive Management of Diabetes and Obesity — Hyatt Regency Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

April 15-16
First Annual Markey Cancer Center Symposium: Biologic Response Modifiers, Lexington, KY. For physicians and nurses. Contact: Hilary Wood, RN, MSN, (606) 257-4500.

April 22-23
Therapeutic Advances in Acute Myocardial Infarction — Hyatt Regency Hotel, Lexington, KY. Contact Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

April 25-May 6
The Johns Hopkins University School of Medicine 29th Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. In-Residence Course B is extremely concentrated lecture series with intensive laboratory studies and vital clinical experience at the Johns Hopkins Institutions, Baltimore, MD. Contact: John K. Frost, MD, 604 Pathology Building, The Johns Hopkins Hospital, Baltimore, MD 21205.

April 29-30
Contemporary Pediatrics for the Practicing Physician — Hyatt Regency Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

May 9-13
Diabetes In-Depth Training Workshop, Lexington, KY. 39 CEUs, $350 (daily rates also available). One week training program in diabetes, effective patient teaching, and setting up a diabetes program. Contact: Paula Gentry, 120 N Eagle Creek Dr, #321, Lexington, KY, (606) 263-5032.

May 10-14
Kentucky Academy of Family Physicians 37th Annual Scientific Assembly, Galt House, Louisville, KY. Contact: KAFP, 3323 Medical Arts Bldg, Louisville, KY 40217, (502) 451-0370.

May 22-27
Nineteenth Family Medicine Review — Session II — Hyatt Regency Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

June 16-18
The 33rd Annual Great Smoky Mountain Pediatric Seminar at the Park Vista Hotel, Gatlinburg, TN. Sponsored by University of Tennessee Medical Center at Knoxville, College of Medicine, Department of Pediatrics, and Knoxville Area Pediatric Society. Contact: Dr Sandra Loucks, University of Tennessee Medical Center, Dept of Pediatrics, 1924 Alcoa Hwy, Knoxville, TN 37920, (615) 544-9331.

Neuroscience Update for the Primary Care Physician

Date
April 30, 1988
Course Director
Lawrence Jelsma, M.D.
Guest Faculty
John Gates, M.D.
Comprehensive Epilepsy Program of Minnesota
Edward Laws, M.D.,
George Washington University Medical Center
Russell Portenoy, M.D.
Memorial Sloan-Kettering Cancer Center
Martin Samuels, M.D.
Harvard Medical School
Objective
Course will provide a neuroscience update for physicians specializing in family and general practice, internal medicine, neurology and neurosurgery.
Program Highlights
- Treatment of seizures
- Early diagnosis, classification and on-going treatment of strokes
- Early detection of brain tumors: surgical and non-surgical treatment
- Pharmacologic management of pain

Registration
Physicians — $25
Others — $15
Accreditation
AMA/Family Practice
Location
Hyatt Regency Louisville
Post-Conference Event
Opening day at Churchill Downs
Information
Janice McMahan, R.N.
Neuroscience Center of Excellence
Humana Hospital – Audubon
One Audubon Plaza Drive
Louisville, Kentucky 40217
(502) 636-7087

NEUROSCIENCE CENTER OF EXCELLENCE
Humana Hospital – Audubon

Highlights of KMA Legislative Seminar

More than 80 people attended the KMA Legislative Seminar held January 6 in Frankfort.

Guest speakers included: Senators Nicholas Z. Kafoglis, MD (D), and John E. Trevey, MD (R); Speaker of the House Donald Blandford (D); John A. "Eck" Rose (D), Senate President Pro Tem; and Senator C. Greg Higdon (D).

A wide range of topics was covered from "AIDS — Emotion vs. Reality" and "Indigent Medical Care — Who is Responsible?" to "Effective Lobbying — Knowing your Opposition — Knowing their Tactics."

The primary focus of the conference was the Task Force Report on Liability Insurance. Speaker of the House Donald Blandford reaffirmed his support for reform and thanked Kentucky physicians for their efforts.

KMA's legislative priorities for the 1988 Kentucky General Assembly were outlined by Wally O. Montgomery, MD, Chairman, Committee on State Legislative Activities. Tom Dorman, Chief Legislative Liaison to Governor Wilkinson, outlined administration goals for the 1988 session.

Richard F. Hench, MD, KMA Past President, spoke on reforming the civil justice system, and KMA President Donald C. Barton, MD, concluded the meeting with a presentation on Professional Liability Insurance. Steve Wilborn, General Counsel to Speaker Blandford and Chairman of the Kentucky Insurance and Liability Task Force, outlined recommendations in the final Task Force report to the KGA.



L to R: Donald R. Chasteen, KMA Director of Public Affairs; Bob M. Deweese, MD, KMA President-Elect; Wally O. Montgomery, MD, Chairman, KMA Committee on State Legislative Activities; William E. Doll, Jr, Legislative Counsel; John P. Cooper, Legislative Consultant

Donald C. Barton, MD,
KMA President





William B. Monnig, MD,
Chairman of
KMA Board of Trustees



Richard F. Hench, MD,
Immediate Past-
President of KMA

Legislative Update — On April 4, 1988, Governor Wallace G. Wilkinson signed the liability tort reform measures which were included in HB 551 and HB 552. HB 551 includes measures relating to joint and several liability; standards of conduct for punitive damages; collateral source rule; and establishes immunity from anti-trust claims for those who participate in "good faith" peer review. HB 552 reforms insurance practices to include extending notification of cancellation or non-renewal from 30 to 75 days and requires insurance companies who increase or decrease their rates by 25% to file rates and obtain prior permission from the Commissioner of Insurance. The Governor permitted HCR 62, which petitions the Supreme Court for several rule changes, to become law without his signature. The signing of the tort reform package culminates a two-year legislative campaign by KMA and other business groups to enact civil changes in our court system and to adopt insurance reform measures. A full explanation of the action by the 1988 Kentucky General Assembly will be included in the April *Communicator*.



Senator Nicholas Z. Kafoglis, MD



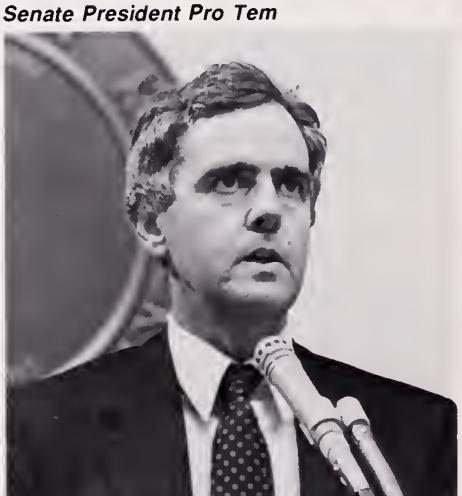
John A. "Eck" Rose, Senate President Pro Tem



Senator C. Greg Higdon



John E. Trevey, MD, Senate Majority Floor Leader



Representative Donald J. Blandford, Speaker of the House



Tom Dorman, Chief Legislative Liaison to Governor Wallace Wilkinson

The "New Look" for Your *Journal* of Your KMA

With this issue, the newly designed presentation of your *Journal* has emerged.

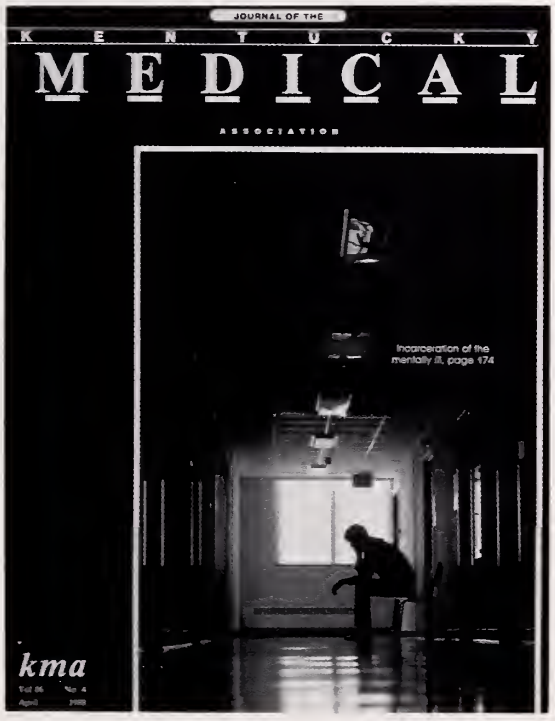
After more than a year of effort — securing permission and money from the Board of Trustees, planning, considering designs and redesigns, agreeing, disagreeing and compromising — we trust our selection for transformation is pleasing.

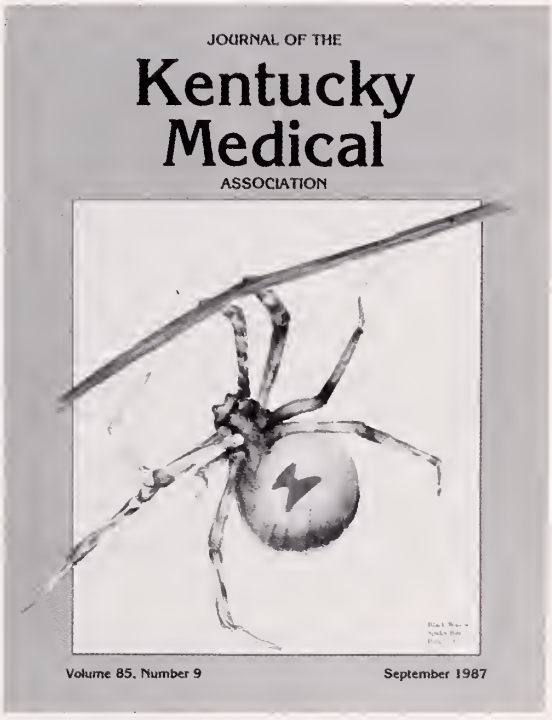
Volume 86, Number 4, April 1988, represents a major milestone, as the change reflected in this edition marks the first complete, overall redesign in the publication's 85-year history. Minor changes in content, typographic style, layout and other elements have occurred constantly through the years. However, as promised, the content has not changed with this latest effort. The redesign project was not geared toward content change, but toward providing a more readable, informative, and up-to-date publication.

The *Journal* is the only publication written by, about and for Kentucky physicians. Here, your image matters more than in any other publication. We are striving to present a *Journal* that projects an image of the active, progressive and professional physicians working throughout the Commonwealth of Kentucky.

This is your *Journal*. The editors are very interested in your reactions, your comments, your criticisms, your suggestions ... and your continued support. We'd like to hear from you.

A. Evan Overstreet
Editor





KEMPAC Elects Officers for 1988

KEMPAC officers elected for 1988 are as follows:

Sam D. Weakley, MD	Chairman
David B. Stevens, MD	Vice-Chairman
K. Thomas Reichard, MD	Treasurer
Paul E. Lett, MD	Assistant Treasurer
Henry R. Bell, Jr, MD	Secretary

The members of the KEMPAC Board of Directors are your representatives and encourage you to discuss political activity in your local area with them.

The districts and directors are:

First Congressional District
Henry R. Bell, MD — PO Box 517, Elkton, KY 42220
Larry Franks, MD — 216 Berger Road, Paducah, KY 42001

Second Congressional District
Francis Halcomb, MD — 217 W Main St, Scottsville, KY 42164
Jerry Martin, MD — 1167 31 W By-pass, Bowling Green, KY 42101

Third Congressional District
K. Thomas Reichard, MD — 100 Baptist East Office Park Bldg, Louisville, KY 40207
Sam D. Weakley, MD — 220 Baptist East Office Park Bldg, Louisville, KY 40207

Fourth Congressional District
Charles F. Allnutt, MD — 2660 Shaker Road, Lakeside Park, KY 41017
John S. Spratt, MD — 529 S Jackson, Louisville, KY 40202

Fifth Congressional District
Harold L. Bushey, MD — 406 Knox Street, Barbourville, KY 40906
Charles C. Moore, Jr, MD — 3603 W Cumberland Avenue, Middlesboro, KY 40965

Sixth Congressional District
John R. Allen, MD — 135 E Maxwell, #104, Lexington, KY 40508
David B. Stevens, MD — 1900 Richmond Road, Lexington, KY 40502

Seventh Congressional District
Samuel J. King, MD — PO Box 3207, Pikeville, KY 41501
Paul E. Lett, MD — 4551 Brenda Drive, Ashland, KY 41101

Represent Auxiliary to KMA
Mrs. Allen Gregory (Joyce), PO Box 848 — Burnside, KY 42519
Mrs. Wally O. Montgomery (Gerry) — 3690 Marlborough Way, Paducah, KY 42001
Mrs. George Schafer (Pat) — 732 Greenridge Lane, Louisville, KY 40207
Mrs. Russell Lee Travis (Sara Gail) — 744 Cottage Grove Lane, Lexington, KY 40502

_____YES, I wish to become a KEMPAC/AMPAC member.

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Personal check enclosed _____ Charge to my credit card _____ VISA _____ MasterCard

_____ / _____
Credit Card No. Expiration Date

Signature _____

If your practice is incorporated, KEMPAC and AMPAC voluntary political contributions should be written on a PERSONAL CHECK. Contributions are not limited to the suggested amount. Neither the AMA nor the KMA will favor or disadvantage anyone based upon the amounts of or failure to make PAC contributions.

A portion of voluntary political contributions will be used in connection with Federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act. Contributions are not tax deductible.

What's new in Cancer Therapy

September 27-29
Hyatt Regency Lexington/Lexington Convention Center
Lexington, Kentucky

Scientific Sessions

The Hyatt Regency Lexington/Lexington Convention Center will host the 1988 Annual Meeting. The Scientific Program Committee has invited speakers from across the nation to participate in the sessions to be held during the mornings of September 27, 28 and 29. The program scheduled for Wednesday will feature William C. DeVries, MD, Humana Hospital Audubon; Russel Patterson, MD, Vice Chairman, Ethics & Judicial Council, AMA; and Andrew Malcolm, First Assistant National Editor, *New York Times*, speaking on, "The Ethics of Death and Dying." Following their presentations will be a question and answer session.

Specialty Groups

Programs for 21 specialty groups will be held during the afternoons of September 27, 28 and 29. No general sessions are scheduled during the specialty group meetings and all KMA members are invited. Scientific sessions and specialty group meetings will be held in the Hyatt Regency Lexington/Lexington Convention Center. By completing CME sign-up sheets at the beginning of each meeting, physicians attending general sessions and specialty group meetings will qualify for Category 1 Credit.

KMA House of Delegates

The opening meeting of the House of Delegates will be held Monday, September 26, at 9 AM in the Hyatt Regency Ballroom, located in the Hyatt Regency Lexington. Reference committee meetings will begin at 2 PM on Monday and the final meeting of the House will begin at 6 PM Wednesday, September 28. Officers for the 1988-89 Associational year will be elected during the final House meeting.

Other Activities

The 26th Annual KEMPAC Seminar will be held Monday evening, September 26, at the Hyatt Regency Lexington. A reception begins at 6 PM with dinner at 7 PM, and the program to follow at 8 PM. Susan Bryant, President of Research/Strategy/Management, Inc., based in Washington, DC, will be the featured speaker.

The President's Luncheon will be held September 28, with presentations of KMA awards and the installation of the 1988-89 KMA President, Bob M. DeWeese, MD. Featured speaker for the luncheon will be the Honorable Brereton C. Jones, Kentucky's Lieutenant Governor.

Scientific and Technical Exhibits will be on display featuring new medical products, services, and techniques. Members and guests have an opportunity to visit this area during the 30-minute intermissions scheduled throughout the general sessions and specialty group meetings.

APPLICATION FOR SCIENTIFIC EXHIBITS

Kentucky Medical Association
1988 Annual Meeting

Hyatt Regency, Lexington, Kentucky
September 26-29

1. Title of exhibit _____

2. Name(s) of exhibitor(s) _____

   Address _____

   Professional title _____

3. Institution if other than exhibitor _____

4. Amount of backwall footage required _____

   (The draped booth has 4′ side walls. This footage should not be included in backwall footage required). TABLE DESIRED? _____

   (Table 2′ deep x width of backwall (footage) ELECTRICAL OUTLET DESIRED? _____

5. Will summary printed matter be available or obtainable for the interested physician? _____

6. Indicate sources of assistance provided to you in connection with this exhibit _____

7. Has this exhibit been displayed before? If so, when & where? _____

   _____

8. It is required that you attach a rough sketch or photograph and a brief outline of your exhibit to include: (a) content of the presentation and (b) the method, eg, equipment to be used.

Date _____ _____

Signature of Applicant

Fill Out and mail to:
RICHARD A. KIELAR, MD, Chairman
Scientific Exhibits Committee
Kentucky Medical Association
3532 Ephraim McDowell Drive
Louisville, Kentucky 40205

The Kentucky Medical Association welcomes and supports scientific exhibits as a facet of continuing postgraduate education.

Applications for space should be received before June 1, 1988.

- KMA provides, without cost to the exhibitor, one 2 ft. table, bracket lights and a title sign.
- Spotlights, view boxes, furniture, decorations, etc, may be furnished by the exhibitor or may be rented, if desired, by applying directly to the George E. Fern Company, 328 Louisville Air Park, Louisville, Kentucky 40213.
- Commercial exhibit materials and handouts are prohibited in the Scientific Exhibit area.
- Transportation and erection costs are the responsibility of the exhibitor.
- Exhibit must be attended during intermissions to answer physicians' questions. It is also desirable to have someone in attendance throughout the program.
- Equipment which will create noise must not be used during the general sessions and, at other times, must be controlled by head or earphones or a muffling device.
- Exhibit must be dismantled and removed by 4:00 PM, Thursday, September 29, 1988.
- Exhibit space is strictly limited to footage and space allotted. No exhibit may extend into the aisle.

Hyatt Regency and the Kentucky Medical Association or its agents cannot guarantee against loss or damage and will assume no liability for damages nor guarantee the exhibitor against loss of any kind. The exhibitor agrees, with the Association, to be responsible to the Hyatt Regency for damages that may occur as a result of the exhibitor's use of the facility.

CLASSIFIEDS

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

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PUBLIC NOTICE — The Cabinet for Human Resources, Department for Social Services is soliciting applications from physicians to provide medical services to juveniles committed to its care and custody for the period of July 1, 1988, through June 30, 1989. Included are routine physical examinations on admission, along with on-site visits to provide emergency and other necessary evaluations and treatment. Services will be purchased for juveniles in the following facilities: Central Kentucky Treatment Center — Jefferson County; Cardinal Treatment Center — Jefferson County; Johnson-Breckinridge Facility — Jefferson County; Morehead Treatment Center — Rowan County; Woodsbend Boys Camp, Morgan County; Lake Cumberland Boys Camp — Wayne County; Mayfield Boys Treatment Center — Graves County; Northern Kentucky Treatment Center — Grant County. The deadline for submittal of completed applications is 4:30 PM, April 20, 1988. Request for application should be addressed to Roy Stivers, Contracts Management Branch, Department for Social Services, 275 East Main St, 6W, Frankfort, Kentucky 40621 or call (502) 564-6750. An Equal Opportunity Employer M/F/H.



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Let our Trust Team manage your retirement assets while you dream about what those funds will do for you.

For more information about the Trust, call our professionals from Prudential-Bache Securities: John C. Schenkenfelder or Thomas O. Eifler at 502-561-5049 or 1-800-633-4248. Or, send in the coupon below.

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Tenth Annual Family Medicine Review

June 5-10, 1988
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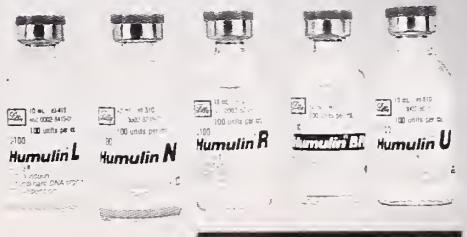
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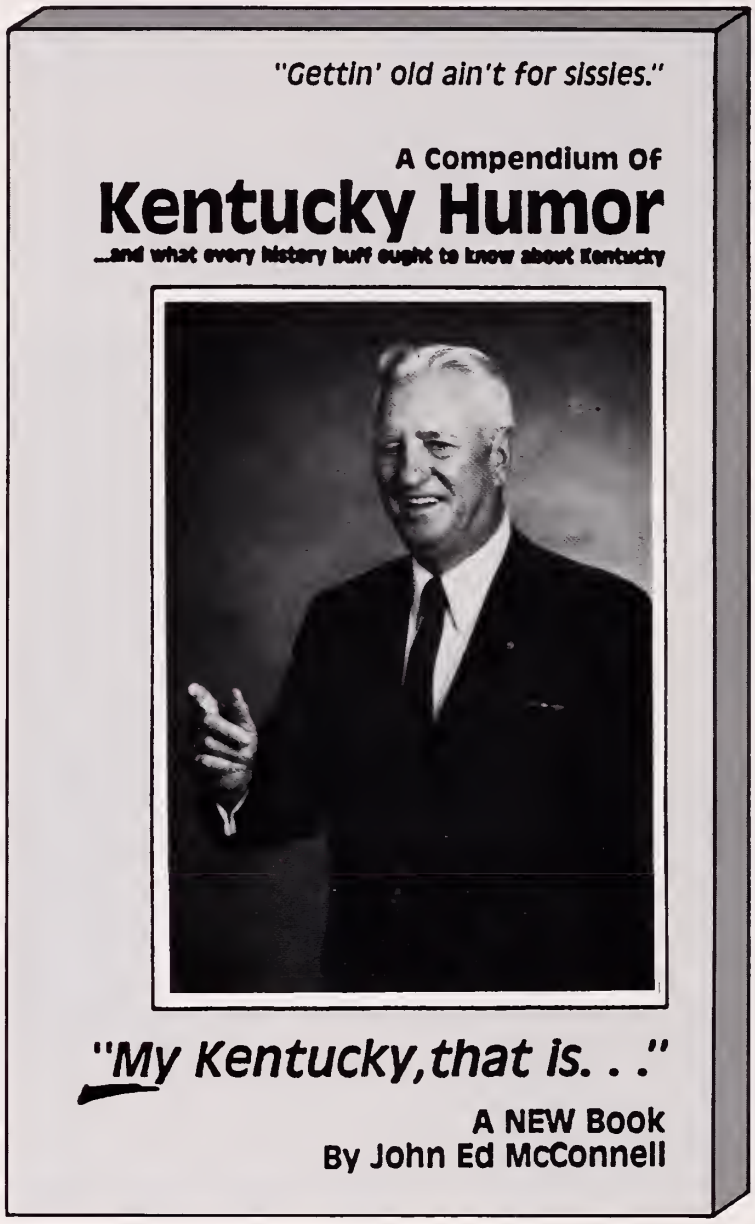
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Ed McConnell, a long-time friend of many Kentucky physicians, retired President of Kentucky Blue Cross and Blue Shield, recipient of many civic awards, and frequent dinner speaker, has written a book . . . a wonderful book of anecdotes and one-liners of Kentucky humor which lends creed to his wisdom, "You can't laugh and feel bad at the same time."



Priced at $12.95 and available in local book stores, or by sending a check or money order to Host Communications Printing, 904 N Broadway, Lexington, KY 40505; or phone your order to: 606-252-6681.

Proceeds from the sale of this book go to macular degeneration research at the University of Kentucky, and the Theresa Hatton Foundation in Frankfort, which provides sheltered family living for handicapped adults.

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- **Support your specific instructions to the patient**
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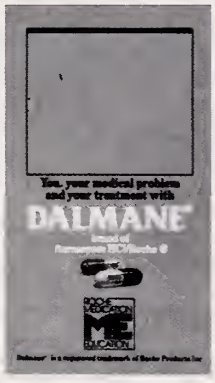
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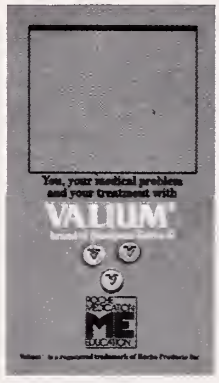
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Program
Page 261

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TABLE OF

CONTENTS

May 1988

Cover:
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SCIENTIFIC

Role of Needle Localization in the Diagnosis of Occult Breast Cancer
Elizabeth A. Amin, MD, and Jack E. Meyer, MD 229

Minoxidil Induced Pericardial Effusion
Paul G. Hovsepian, MD; Humberto Coto, MD; Abraham Joseph, MD; Joel Kupersmith, MD 235

Organ Donation in Kentucky (Grand Rounds)
Frederick R. Bentley, MD, and R. Neal Garrison, MD 243

EDITORIAL

Sidewalks 249

SPECIAL ARTICLE

The Foundation of the Jefferson County Medical Society 251

ASSOCIATION

A Dream 258
Nominations Being Accepted for Three Annual KMA Awards 260
KMA-HMSS Annual Meeting Scheduled for June 260
Emergency Medical Care Seminar Program 261
Annual Meeting Preview 263

REGULAR FEATURES

President's Page 225
Auxiliary 253
CME 265
Classified 264
Information for Authors 246
Letters to the Editor 255
In Memoriam 257

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VOL 86 NO. 5
MAY 1988

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May Buyer's Guide

Charleston Area Medical Center 227
Classified 264
Differential Advantage, Ltd. 254
Elcomp Systems, Inc. 250
KMA Insurance Agency, Inc. 220, 256
KMIC 248
KMIC Investment Company 240
KMIC Leasing Company 216
Eli Lilly & Company 226
Marion Laboratories 240-241
Medical Protective Company 239
Methodist Evangelical Hospital 247
PIE Mutual Insurance Company 252
Palisades Pharmaceuticals 254
Physicians International 264
Roche Laboratories 268-270
Skycare, Inc. 228
Smith, Kline & French Laboratories 267
U.S. Air Force 228
U.S. Army Reserve 238, 242
University of Louisville School of Medicine 254
Wyeth-Ayerst Laboratories 221-224

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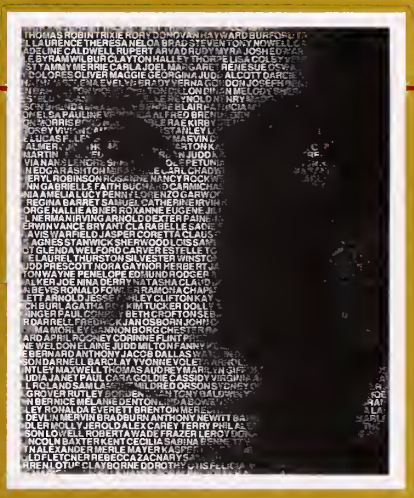
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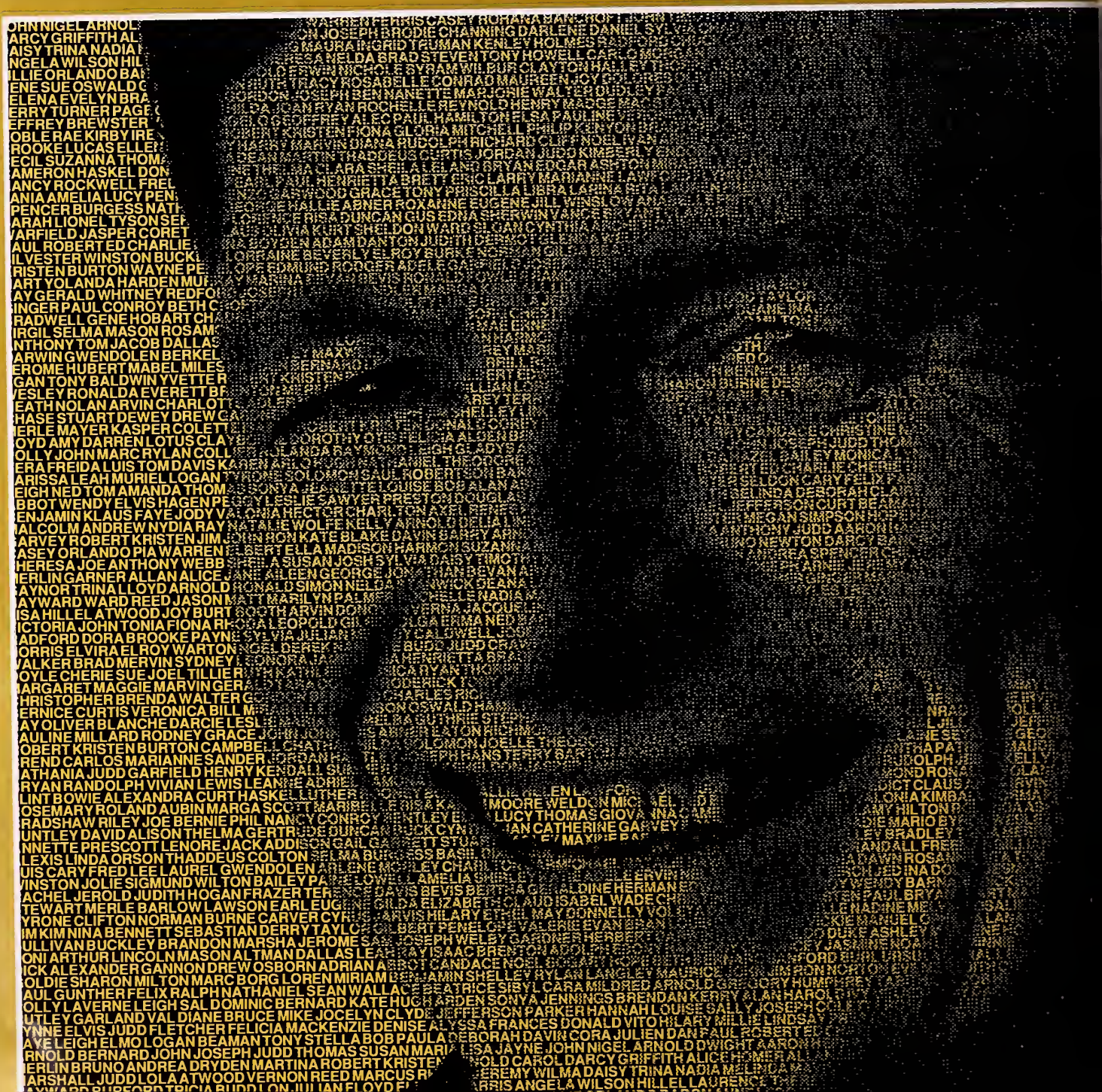
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Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Auto-Immune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

*The appearance of these capsules is a registered trademark of Ayerst Laboratories.

Reference:

1. Data on file, Ayerst Laboratories.

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PRO

Just three letters out of twenty-six, but when they are put together they are discussed and cussed more than the other twenty-three combined. Why don't we just get the PRO law repealed? There are many valid arguments that can be made in behalf of repeal. For example: insufficient onsite review; over-emphasis on cost and utilization reduction; inordinate emphasis by some PROs on nonphysician reviewer determinations combined with perceived perfunctory review by physician peers; concerns as to the qualifications of PRO physician reviewers; and the inability of the attending physician, in most cases, to learn the identity of these usually anonymous reviewers are some of the more common complaints. All of the above specific complaints are largely legitimate and justified.

Under the circumstances, I feel the appropriate stance of our associations should be to identify and actively seek modifications to those onerous aspects of the program's operations. We must continue a stance which maintains our credibility in the areas of quality and cost consciousness.

The AMA has caused improved sanction due process, proposed legislative reforms of the sanction process, and has had introduced in Congress other PRO reform legislation, including a proposed requirement for PROs to conduct onsite meetings at least quarterly with medical and administrative staffs of rural hospitals.

PROs are also expanding beyond hospital review, as they carry out new congressional directives to monitor quality of care provided in ambulatory surgical centers, hospital out-patient departments, skilled nursing facilities, and home health agencies. Care provided to beneficiaries in private medical practices are not subject to mandatory Medicare PRO review until January 1, 1989. Since the great majority of Medicare patients are seen in this setting, pressure to review care provided in physician offices is likely to persist. We are kidding ourselves if we assume this would be *quality* of care review. As pressure to control the volume of physician services continues, PROs—or, more likely, the Part B carriers—may be directed to apply more stringent *utilization* screens to care provided in the private physician's office. Draft AMA federal legislation would amend the PRO law to provide that PROs "shall not review services provided in a physician's private office and shall not inspect a physician's private office."

Your KMA has established a Peerview Oversight Committee to help deal with all these varied problems. Peerview has asked for our cooperation, and I feel this committee can be helpful to our members and also we can be beneficial to the problems of Peerview. The Feds have not been totally fair in their negotiations for the PROs. Any improper negotiating tactics by the government are not simply a problem for the PROs, but to all physicians interested in true peer review which focuses on quality assurance. However, it is important to recognize that while many of the problems of PRO program administration are traceable to some defect in federal law or regulation or the contractual scope of work, many other problems arise because of the manner in which a specific PRO carries out its contractual responsibilities.

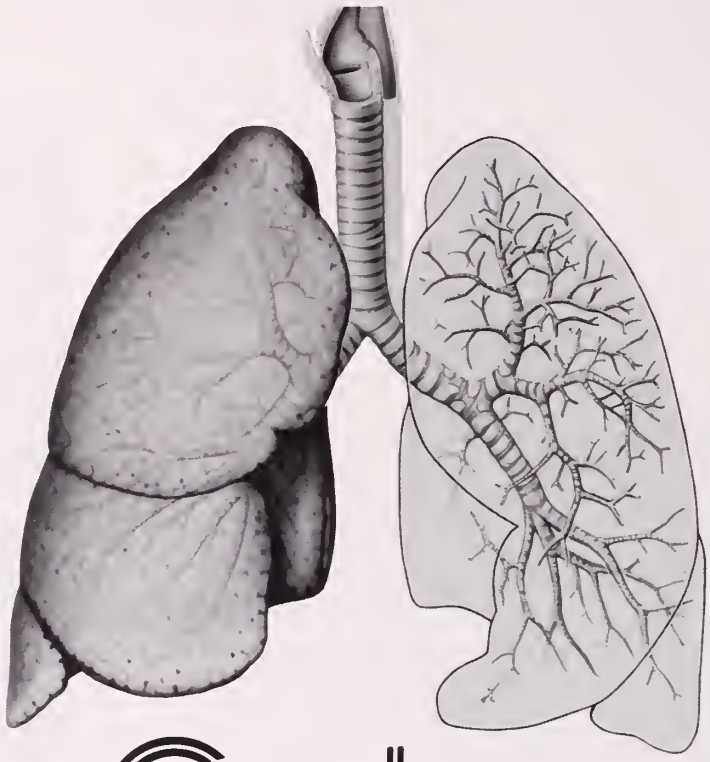
I think this committee could be the opportunity for our physicians and KMA to help direct the workings of Peerview and to positively influence the way they carry out their quality and utilization review responsibilities, with a sensitivity towards the clinical complexities and real life needs of elderly Medicare patients.

I leave you with two thoughts: Elie Wiesel said, "There may be times when we are powerless to prevent injustice, but there must never be a time when we fail to protest." The second: "Quality is remembered long after price is forgotten." — Stanley Marcus.



Donald C. Barton, MD
KMA President

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- Prolonged use may result in overgrowth of nonsusceptible organisms.
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- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
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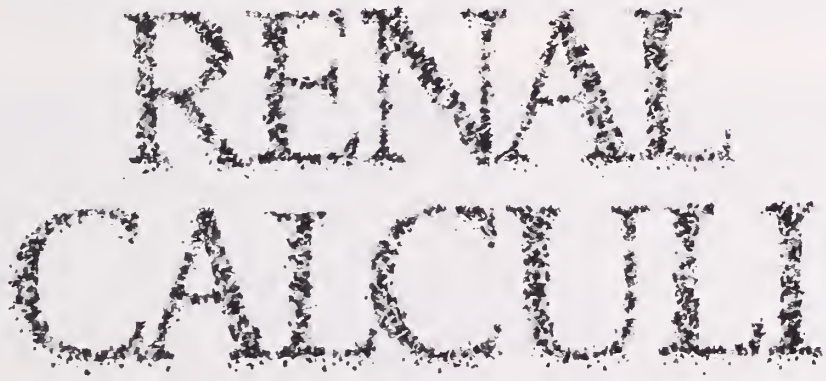
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Role of Needle Localization in the Diagnosis of Occult Breast Cancer

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Pre-operative needle localization is essential for the accurate excision of mammographic abnormalities suggestive of malignancy. Since 1966 a number of different localization techniques have been reported. The method and the results of 102 percutaneous breast needle localizations performed at the University of Louisville during the past 24 months are described. Cancer was detected in 14 of 102 biopsies. In 97 of 102 biopsies the abnormality was removed in the first specimen. Only one patient required a repeat surgical procedure. Morbidity was minimal and no cosmetic deformity was produced in any of the patients.

Introduction

The treatment of early breast cancer includes options which allow for the preservation of breast tissue.[1,2,3] These are important to women of all age groups and appear to diminish somewhat the psychological burden which a diagnosis of breast cancer imposes.[4] A more aggressive search for occult breast cancer has resulted in the identification of mammographic findings other than the classic spiculated mass and the clustered punctate or linear/branching microcalcifications with which clinicians are now familiar. These abnormalities include: (1) an ill defined soft tissue mass; (2) architectural distortion without mass or microcalcifications; (3) asymmetry of breast parenchyma; (4) developing density in the postmenopausal breast; (5) a solitary dilated duct.[5]

If each of the mammographic findings is evaluated separately, the solitary cluster of microcalcifications yields the highest number of cancers.[6] Even with the strictest mammographic criteria and meticulous pathologic correlation, the positive prediction rate for this finding is only 25% to 33%. The "typical" spiculated mass is found in only 7% to 10% of clinically occult cancers.[7] Since the secondary signs have even greater degrees of non-specificity, breast biopsies performed on the basis of mammographic findings "suggestive of malignancy" will include a large number of benign histologic diagnoses.[8] In addition, there are a number of women who upon learning that they have a "probably benign" finding on routine mammography are unwilling to wait for a follow-up study and anxiously request immediate biopsy.

The combination of needle localization and excisional biopsy of clinically occult breast lesions provides a reliable method for the accurate histologic diagnosis of mammographically suspicious findings. The procedure should result in minimal morbidity and produce a satisfactory cosmetic result. Dedicated mammographic units and self-retaining wires facilitate accurate localization of the abnormality by the radiologist.[9] A cooperative interaction of radiologist, surgeon and pathologist should insure that the abnormality identified mammographically is actually that on which the pathologist makes the final histologic diagnosis.

Materials and Methods

During the 24 months from July 1985 through June 1987, 102 consecutive needle localizations were performed on 97 patients referred to the Department of Diagnostic Radiology at Humana Hospital-University. The localization technique and results have been analysed with regard to: (1) patient tolerance and morbidity; (2) presence or absence of the abnormality in the initial biopsy specimen; (3) size of biopsy specimen; (4) pathologic findings.

The method described requires the abnormality to be identifiable in both projections of the original mammograms and a cooperative patient. CT guidance permits localization of occult lesions identifiable on only one view of the mammogram or in patients who are unable to sit.[10] It is possible, however, to accurately localize abnormalities seen in only one mammographic projection utilizing triangulation.[11]

All our localizations were performed on a C.G.R. Senographe 500T dedicated mammographic unit using the Kopans Spring Hook Localizer needle (Cook, Bloomington, IN) with the patient seated. Premedication is neither required nor desirable and local anesthetic was not routinely administered.

From the original mammogram the position of the abnormality is determined in relation to the skin surface. Ideally the shortest skin to lesion distance is selected and the breast compressed in the appropriate cranio-caudal, mediolateral, or lateral medial projection. A special fenestrated plate allows access to the skin and the "window" is positioned over the area of abnormality. The position is confirmed by a scout film (Fig 1). The number/letter grid allows the

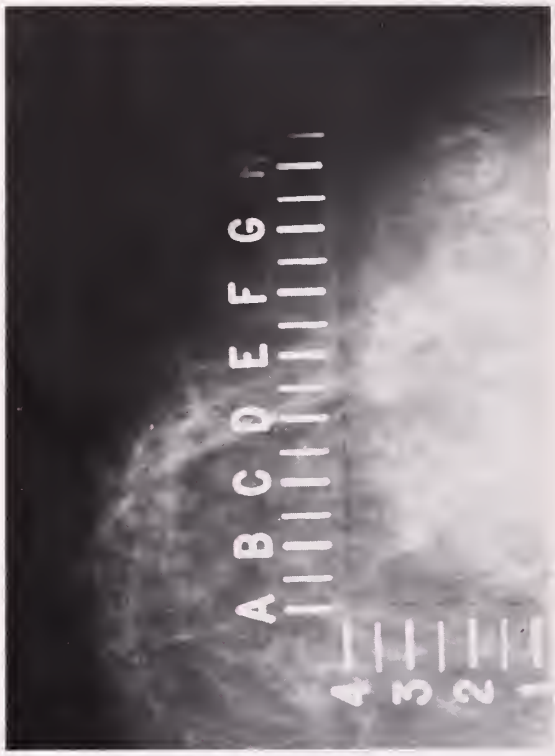


Fig 1. Stellate mass with occasional microcalcifications centered along "E" and 3 coordinates.

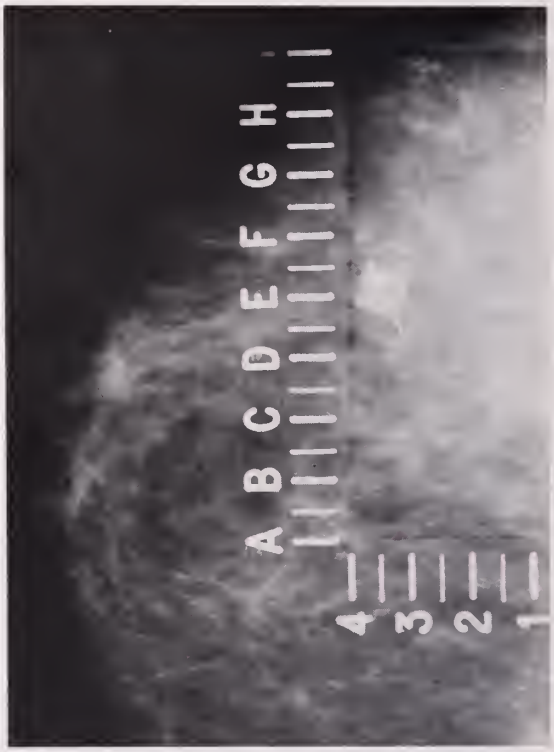


Fig 2. Initial needle placement.

location of the abnormality to be projected onto the skin and the needle is inserted perpendicular to the plane of the skin and parallel to the chest wall. An x-ray film is then obtained and if necessary the needle can be adjusted for optimum alignment (Fig 2). The breast is filmed in the 90 degree opposing projection, in the plane of the localizer for assessment of depth (Fig 3). An additional film is usually not required prior to adjustment and removal of the needle. The hook is opened (sprung) by applying mild traction on the wire after the needle has been withdrawn a short distance. The hook will thus be fixed in the region of interest and the needle can be completely removed (Fig 4).

After the breast has been allowed to return to its normal, uncompressed state the wire is loosely taped to the skin. The patient is escorted to the OR with all pertinent films appropriately marked to assist the surgeon in the performance of the biopsy. The radiologist then awaits receipt of the specimen.

Radiographic evaluation of the biopsy specimen includes a compression view: (A) unmagnified for masses (Fig 5a); (B) 1.5 magnification for calcium (Fig 5b). If the abnormality is not



Fig 3. Tip of needle is just below mass.

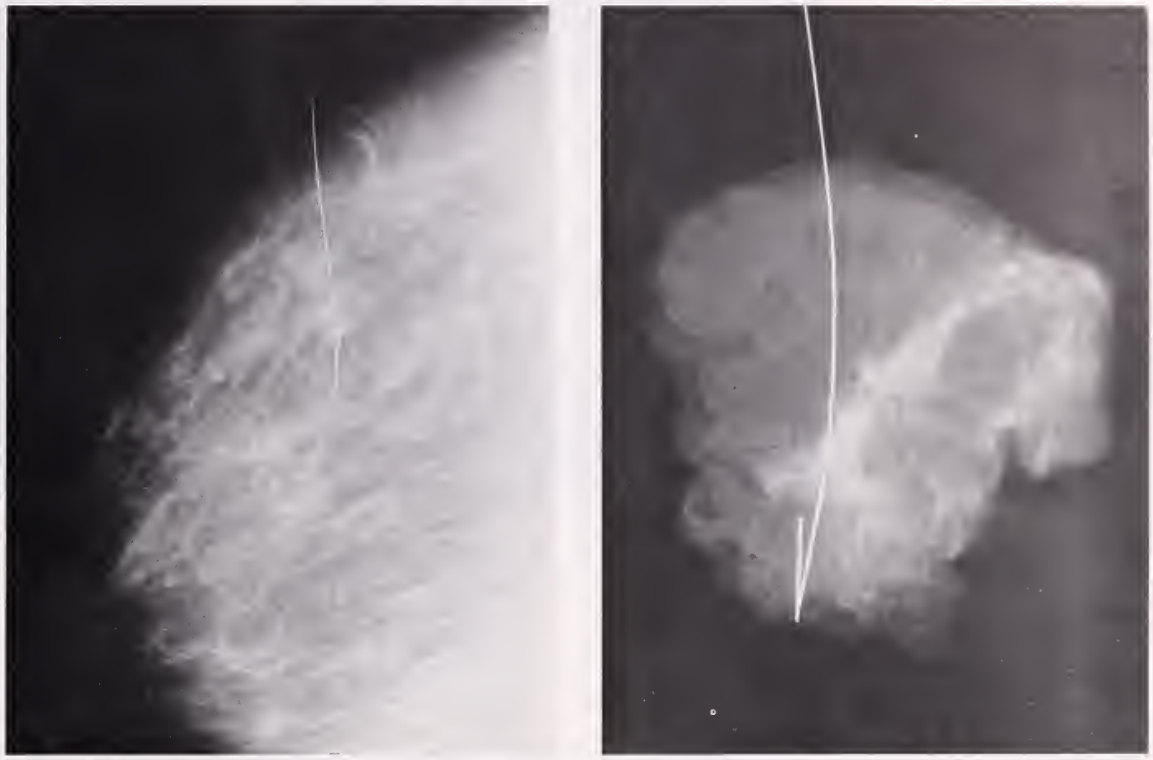


Fig 4. (A) Final film after removal of needle. (B) Photographic magnification of compressed specimen. (Actual dimensions 3½ x 3½ cm²). Infiltrating ductal carcinoma.

detected in the original specimen additional tissue may be obtained, but if it does not contain the abnormality, it is recommended that surgery be discontinued and a mammogram be performed at a later date after healing. Once the presence of the abnormality is confirmed, the specimen is taken to Pathology for initial sectioning. If the specimen is large and/or the abnormality is small, it is useful to recut and re-x-ray the specimen for more accurate identification (Fig 6).

Results

One hundred and two localizations were performed on 97 patients. One of the patients had two localizations in the same breast (both foci of infiltrating ductal carcinoma) and four had bilateral localizations. Of this group, two patients experienced vaso vagal reactions, one in association with mild intramammary hemorrhage. Both localizations were successfully completed. All patients were comfortable walking the distance from the x-ray department (basement) to the outpatient surgical suite (2nd floor).

Of the biopsies performed, 97 of 102 (97%) showed successful removal of the abnormality as confirmed on specimen radiography or on palpation by the surgeon. In four patients additional biopsy material was taken to remove calcifications. Only one patient was required to return for a second surgical procedure because of persistence of the abnormality on a follow-up mammogram. This was a fibroadenoma in a patient status post mastectomy with diffuse metastases.

Radiography should be performed on all biopsy specimens except those in which the abnormality becomes readily palpable during surgery. Eighty-seven specimen radiographs were available for evaluation. The size of the biopsy was measured from the compression radiograph. (The thickness of a number of compressed specimens was evaluated and varied from 6 mm to 1 cm thus specimen sizes were recorded in cm^2.) The range is from 1.0 cm^2 (a small fibroadenoma readily palpable after surgical incision revealed the lesion) to 36.0 cm^2. (Median 9.0 cm^2.) Biopsies tended to be larger in larger breasted women and in the removal of amorphous soft tissue masses. None of the patients is reported to have any cosmetic deformity at the time of surgical follow-up.

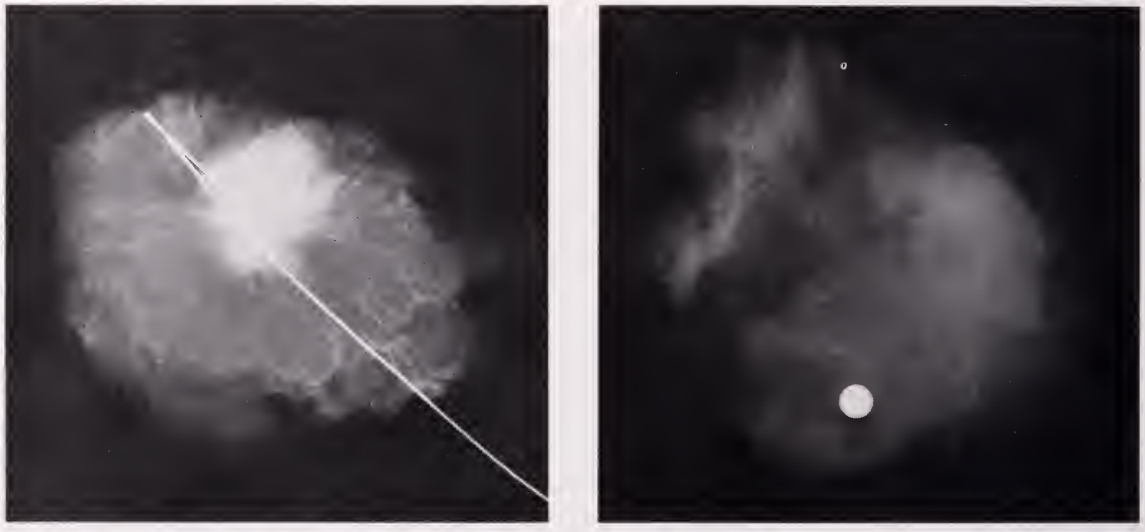


Fig 5. (A) Infiltrating ductal carcinoma. (Actual dimensions 4 x 3 cm².)
(B) Intraductal carcinoma (magnification view) microcalcifications clustered to left of metallic marker marked to facilitate frozen sectioning.



Fig 6. (A) Magnified specimen. (B) After recutting and re-x-raying: microcalcifications are identified in specimen 3.

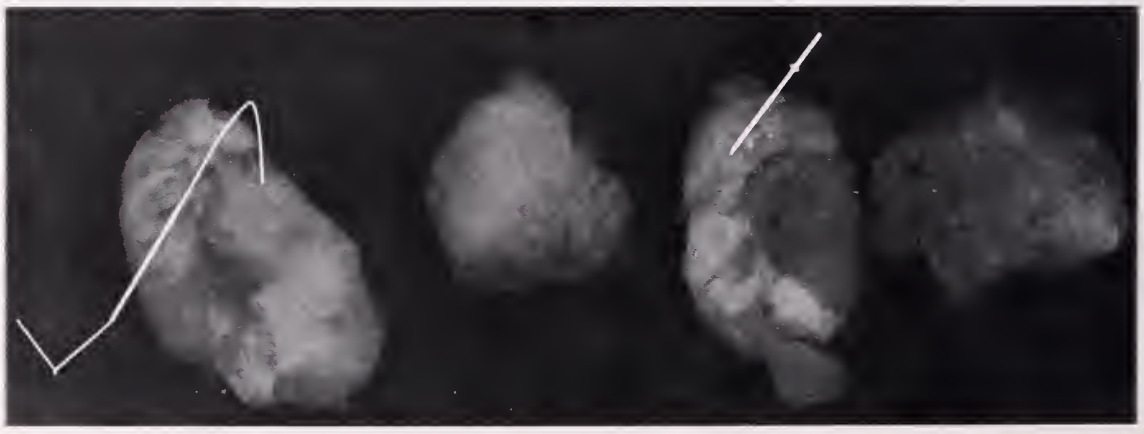


TABLE I
PATHOLOGIC CLASSIFICATION

MALIGNANT DIAGNOSES	
Infiltrating Ductal Carcinoma	6
Intraductal Carcinoma	3
Mixed Lobular and Ductal (Infiltrating)	2*
Infiltrating Papillary with Tubular Component	1
Tubular Carcinoma	1
Diffuse Intraductal Comedo Type with Infiltrating Foci	1
Total	14

* Bilateral at time of initial biopsy

Of the 102 localizations performed 14 revealed malignancy. Four of the cancers occurred in three patients who had a previous diagnosis of malignancy in the opposite breast. Of the four patients who had bilateral localizations, one had bilateral malignancy, two had malignancy in one breast only. The fourth had bilateral fibroadenomas (Table 1).

Discussion

Mammographic screening is established as the primary method of detection of clinically occult breast cancer[12] but the radiographic manifestations of malignancy are often relatively nonspecific. A number of authors have reported the pathologic correlation with various mammographic findings. In 1980, Egan et al classified the characteristics and distribution patterns of microcalcifications in 468 biopsies.[6] Cancer was detected in 115 (24.5%). Clusters of more than 10 calcifications were identified in 84% of the cancers and in 54% benign biopsies. In 1983, Sigfusson et al reported a 33% incidence of malignancy in biopsies performed for evaluation of suspicious microcalcifications without soft tissue changes.[13] Both of these reports stress the similarity of the calcifications in benign and malignant lesions.

In a report by Meyer et al, of 500 biopsies performed for mammographically suspicious findings, 23.4% were shown to be malignant.[14] Two hundred and three of the 500 were performed to evaluate suspicious microcalcifications without soft tissue changes and of these 22% were shown to be malignant. Similar findings were reported by Grisvold and Martin in their series of 343 non-palpable mammographic abnormalities.[15]

In Moskowitz's series of 205 clinically occult breast cancers, 20.5% were detected on the basis of microcalcifications alone and 6.8% were considered "definitely malignant" masses.[16] Sickles[17] documented 300 consecutive non-palpable breast cancers identifying the spectrum of radiographic signs associated with these tumors. Forty-two percent were detected by the presence of clustered microcalcifications but in only 54% of these were the microcalcifications "typical" of malignancy. He also noted that almost 20% of the cancers were detected by the presence of the "secondary" signs of malignancy.

Thus the percentage of malignant diagnoses in the biopsies performed on mammographically suspicious findings varies from the 10% advocated by Moskowitz[17] to 25% reported in other series.

Summary

There is good evidence that the diagnosis of breast cancer at its earliest stage will result in reduced mortality.[7] Mammography has been established as the principal method of detecting clinically occult breast cancer. The role of needle localization is to facilitate biopsy of mammographically suspicious findings in asymptomatic women. Since greater than 70% of all biopsies will prove benign the surgical procedure should be safe and cosmetically acceptable. Meticulous attention to the performance of the localization by the radiologist, in close co-operation with the surgeon and pathologist, ensures the highest possible accuracy with the least possible morbidity.

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Minoxidil Induced Pericardial Effusion

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Joel Kupersmith, MD

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A case of minoxidil-induced pericardial effusion is reported in a 50-year-old male with chronic moderate essential hypertension and no history of congestive heart failure, chest trauma, prior myocardial infarction, renal insufficiency or connective tissue disease. The patient was admitted to a coronary care unit and treated with nifedipine, furosemide and digoxin. Apparently, there are a small number of patients who develop pericardial effusions during minoxidil therapy. This complication may be life-threatening, therefore, such patients should be carefully monitored for evidence of cardiac enlargement or increasing amounts of pericardial fluid.

Introduction

Minoxidil is a potent, direct acting peripheral vasodilator that has been used in the treatment of hypertension, especially in combination with other antihypertensive agents. Although, in general, few side effects are reported with this agent, it has been associated with pericardial effusions. Pericardial effusions secondary to minoxidil have occurred in patients with congestive heart failure, in chronic dialysis patients, or patients with a systemic disease.[1] There have also been isolated reports of minoxidil induced pericardial effusions without other underlying cause[2] despite exhaustive investigation.

Case Report

A 50-year-old black male was admitted to Humana Hospital University, Louisville, Kentucky, in January 1987 with severe respiratory distress. He had been treated with chlorthalidone 25 mg daily, alpha-methyldopa 50 mg bid, and minoxidil 2.5 mg also twice daily for chronic moderate essential hypertension for the past 12 months. There was no history of congestive heart failure, chest trauma, prior myocardial infarction, renal insufficiency, or connective tissue disease.

At the time of admission, his blood pressure was 200/140 and his heart rate was 118 bpm. On examination, the patient was not in congestive heart failure and there was no pulsus paradoxus. Initial ECG disclosed a left bundle branch block and a chest x-ray film showed cardiomegaly with no evidence of pulmonary congestion heart failure.

There were no abnormalities in routine laboratory examination apart from an erythrocyte sedimentation rate (ESR) of 33 mm/hr. Serial cardiac enzymes and isoenzymes were negative for myocardial infarction. Thyroid function studies were normal.

The patient was admitted to the coronary care unit. A 2-D echocardiogram revealed mild concentric left ventricular hypertrophy, good myocardial function, a large pericardial effusion, and right ventricular free wall collapse during diastole (Fig 1).

Hemodynamic monitoring performed with a triple lumen catheter disclosed the following pressures (mm/Hg): mean right atrium 15, right ventricle 38/16, pulmonary artery 38/18, and pulmonary capillary occlusion pressure 18. The cardiac output was 3.01 L/min.

Approximately 250 cc of clear yellow fluid were removed during pericardiocentesis and sent for analysis. Repeat echocardiograms revealed the persistence of pericardial fluid. A computerized tomography of the chest (Fig 2) showed cardiomegaly and a large pericardial effusion but was otherwise negative. A pericardial biopsy via thoracotomy was then performed and 350 cc of fluid were further removed and sent again for analysis disclosing a WBC count of 900 cells with 98% lymphocytes, protein 5.7 G/DL (serum 5.0 G/DL), LDH 200 (serum 154 G/L). Aerobic and anaerobic pericardial fluid cultures, as well as cultures for tuberculosis and fungus were negative. Viral titers and other studies were normal. Pericardial biopsy showed eroded mesothelium and a minute, nonspecific inflammatory reaction. Pericardial fluid cytology revealed no evidence of malignancy and connective tissue disease workup was negative.

The patient's blood pressure was controlled with nifedipine 20 mg every six hrs, furosemide 80 mg daily, digoxin 0.25 mg daily. Minoxidil therapy was discontinued. He was discharged from the hospital and follow-up revealed a stable cardiovascular status.

Discussion

Minoxidil is a potent anti-hypertensive drug which is a potent oral vasodilator acting directly on arteriolar smooth muscle. Few serious side effects have been reported[1] and these have been

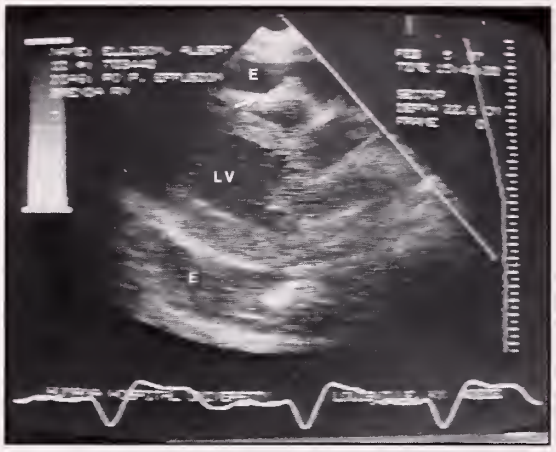


Fig 1. Parasternal long axis during diastole showing collapse of the free wall of the right ventricle (see arrow) and a huge anterior and posterior effusion (E).

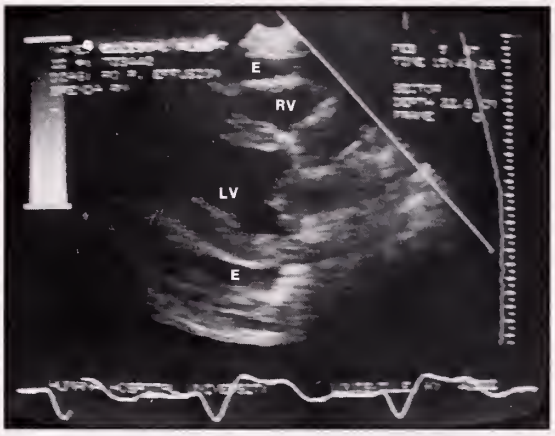


Fig 2. Parasternal long axis view during systole. (E) = effusion, (RV) = right ventricle, (LV) = left ventricle.

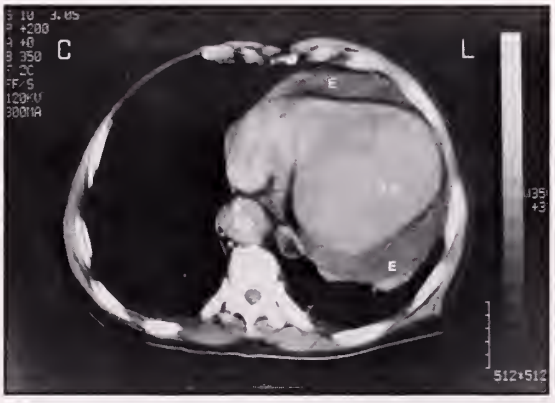


Fig 3. CT scan of the chest showing a large pericardial effusion (E) extending anterior and posterior to the left ventricle (LV).

treated with appropriate concomitant therapy. Side effects observed during Minoxidil therapy have included hypertrichosis, sodium retention, and reflex tachycardia[3] which may occasionally result in angina. Reflex tachycardia has been controlled with propranolol therapy while sodium retention has been treated with diuretics. Review of the literature indicates that pericardial effusions, although uncommon, may occasionally occur in patients receiving Minoxidil therapy.[1,2,4,5] Numerous mechanisms for this have been proposed although the true etiology remains uncertain.

In a review by Martin et al[1] of pericardial disorders occurring during open label study of hypertensive patients treated with Minoxidil, 73 cases of pericardial effusion were noted. All but nine of these patients had an identifiable cause for the pericardial effusion. These causes included severe renal failure, congestive heart failure, SLE and tuberculous pericarditis. In five of the nine cases reported in that study, the pericardial effusions subsided despite the fact that Minoxidil therapy was continued. This suggests that this drug was not causal. All patients in his study had marked renal and cardiac abnormalities which could have explained pericardial effusions.

Reichgott[3] studied the use of Minoxidil in 48 patients with severe hypertension. Pericardial disease was identified in ten patients, nine of whom had pericardial effusion (24.3%) and one of whom had transient pericarditis (2.7%). In one of his patients, rechallenge of Minoxidil caused reaccumulation of an effusion that in time disappeared when therapy with the drug was stopped. In an additional four patients, pericardial effusions resolved only when Minoxidil was discontinued. Reighcott therefore postulated that an idiosyncratic drug reaction was responsible for the pericardial effusion. The unpredictability of the reaction, and the fact that it is not dose related nor a function of the duration of therapy, appeared to support the hypothesis that the pericardial effusion developed secondary to an idiosyncratic drug reaction. His study also noted that impaired renal function and volume retention did not appear to be the contributing causes in producing effusions in his study group.

In the present case, hemodynamic measurements obtained before and after pericardiocentesis indicate that overt congestive heart failure was not the cause of pericardial effusion. An echocardiogram revealed a normally contracting left ventricle with a normal ejection fraction and

no evidence of hypokinesis. Analysis of the pericardial fluid did not reveal any specific cause. Although the fluid was an exudate, all cultures including AFB and fungal cultures as well as cytologic studies were negative. There was no history of chest trauma or radiation. The patient was not on anticoagulants and there was no evidence of renal disease or systemic illness, fever, chills, or weight loss. His ESR was low and there was no immunologic evidence to suggest the presence of a connective tissue disorder. Thyroid function tests were also normal.

Conclusion

We do not have conclusive evidence that the pericardial effusion in our patient was due to minoxidil. We did not consider a rechallenge with drug to be judicious. However, the lack of other underlying causes in this afebrile patient suggests minoxidil as a cause of the effusion as is consistent with the strong suggestion of other observers. We would advise observation for this occurrence and possible withdrawal of drug in all patients undergoing systemic minoxidil therapy.

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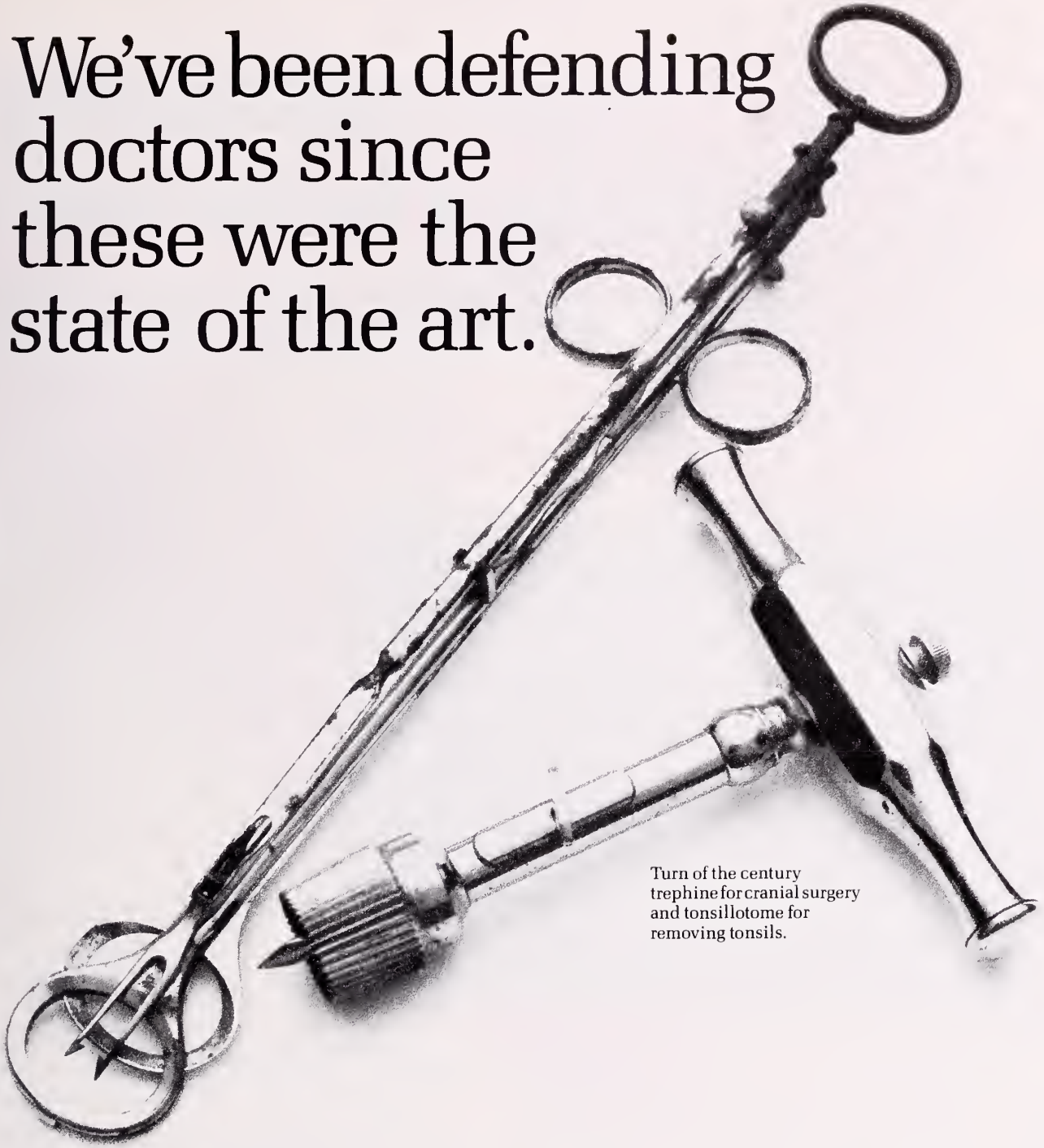
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CONTRAINDICATIONS
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PRECAUTIONS
Duodenal ulcer is a chronic, recurrent disease. While short-term treatment with sucralfate can result in complete healing of the ulcer, a successful course of treatment with sucralfate should not be expected to alter the post-healing frequency or severity of duodenal ulceration.

Drug Interactions: Animal studies have shown that simultaneous administration of CARAFATE (sucralfate) with tetracycline, phenytoin, digoxin, or cimetidine will result in a statistically significant reduction in the bioavailability of these agents. The bioavailability of these agents may be restored simply by separating the administration of these agents from that of CARAFATE by two hours. This interaction appears to be nonsystemic in origin, presumably resulting from these agents being bound by CARAFATE in the gastrointestinal tract. The clinical significance of these animal studies is yet to be defined. However, because of the potential of CARAFATE to alter the absorption of some drugs from the gastrointestinal tract, the separate administration of CARAFATE from that of other agents should be considered when alterations in bioavailability are felt to be critical for concomitantly administered drugs.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Chronic oral toxicity studies of 24 months' duration were conducted in mice and rats at doses up to 1 gm/kg (12 times the human dose). There was no evidence of drug-related tumorigenicity. A reproduction study in rats at doses up to 38 times the human dose did not reveal any indication of fertility impairment. Mutagenicity studies were not conducted.

Pregnancy: Teratogenic effects. Pregnancy Category B. Teratogenicity studies have been performed in mice, rats, and rabbits at doses up to 50 times the human dose and have revealed no evidence of harm to the fetus due to sucralfate. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers: It is not known whether this drug is excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when sucralfate is administered to a nursing woman.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
Adverse reactions to sucralfate in clinical trials were minor and only rarely led to discontinuation of the drug. In studies involving over 2,500 patients treated with sucralfate, adverse effects were reported in 121 (4.7%).

Constipation was the most frequent complaint (2.2%). Other adverse effects, reported in no more than one of every 350 patients, were diarrhea, nausea, gastric discomfort, indigestion, dry mouth, rash, pruritus, back pain, dizziness, sleepiness, and vertigo.

OVERDOSAGE
There is no experience in humans with overdosage. Acute oral toxicity studies in animals, however, using doses up to 12 gm/kg body weight, could not find a lethal dose. Risks associated with overdosage should, therefore, be minimal.

DOSAGE AND ADMINISTRATION
The recommended adult oral dosage for duodenal ulcer is 1 gm four times a day on an empty stomach.

Antacids may be prescribed as needed for relief of pain but should not be taken within one-half hour before or after sucralfate.

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Issued 1/87

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Soldier being examined for effects of high-altitude cerebral edema.

ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow, Massachusetts General Hospital, Boston, Massachusetts. Captain, U.S. Army Reserve.

EDUCATION Ithaca College, B.A. (Magna Cum Laude); Hamilton College (Pre-med); Harvard Medical School.

RESIDENCY General Surgical Internship. Neurosurgical Residency, Massachusetts General Hospital.

CONTINUING EDUCATION Neurology and Neurosurgery Research Fellowship Training, National Institutes of Health.

OUTSTANDING ACHIEVEMENTS Olsen Memorial Fellowship, National Masonic Medical Research Foundation; Albert Schweitzer Fellowship, International Albert Schweitzer Foundation; Harvard Medical School Cabot Prize for Best Senior Thesis; recently published article, "Who Shall Live and Who Shall Die" in Newsweek Magazine.

"The work I'm doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn't ask for a smoother transition. And that's true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

"Some of the projects the Army is undertaking are on the cutting edge of research. For example, I'm currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

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Organ Donation in Kentucky

Frederick R. Bentley, MD
R. Neal Garrison, MD

Frederick R. Bentley, MD, Transplant Surgery, Assistant Professor of Surgery, University of Louisville. R. Neal Garrison, MD, Medical Director of Kentucky Organ Donor Affiliates, Associate Professor of Surgery, School of Medicine, University of Louisville, Louisville, KY 40292.

One of the major success stories in the 1980s has been the growth and maturation of organ transplantation. Results in solid organ and tissue transplants have increased dramatically during the last few years. With this increased demand and success in organ transplantation has come a persistent and worsening shortage of transplantable organs. About 20,000 potential donors for solid organs are available in the United States each year. In only about 15% of cases are organs or tissue recovered. Barriers to organ donation exist in both the lay public and the health care professions. More education of the public and health care professionals is needed to adequately utilize this resource. Kentucky has made progress in the area of organ donation by enacting laws defining brain death, and laws requiring hospitals to institute routine request. Kentucky also has a new statewide organ procurement agency, Kentucky Organ Donor Affiliates.

One of the major success stories in medicine in the 1980s has been the growth and maturation of organ transplantation. Patients with diseases thought incurable ten years ago now have transplantation as a viable alternative form of therapy. Results in solid organ and tissue transplants have increased dramatically during the last few years due primarily to better understanding of transplantation immunology and control of the rejection process. Cyclosporine, monoclonal antibody therapy, and unique drug protocols have lessened the morbidity of immunosuppression and allowed a significant increase in the population now considered transplant candidates. One year graft survival results for renal transplantation are currently averaging 75% to 95%, depending on donor organ source (living related or cadaver), and for cardiac and hepatic transplantation, where one year graft survival is synonomous with patient survival, the results are 75% to 85% and 60% to 70% respectively. In 1986, there were 10,566 renal transplants, 1,368 heart transplants, 924 liver transplants and 130 pancreas transplants performed in the United States (Table I). For the same year at any given time, there were approximately 9,000 people waiting for kidney transplants, 300 for a cardiac transplant, and another 300 for a liver transplant. All of these figures have increased dramatically in 1987.

With this increased demand and success in organ transplantation has come a persistent and worsening shortage of transplantable organs. Many people are still dying while waiting for a suitable liver or heart donor. There are over 80,000 people in the United States on chronic dialysis therapy today and about 20,000 new patients are added to this end-stage-renal-disease population each year. If one accounts for deaths while on dialysis, successful transplantation, and other factors, there is a net increase of about 6,000-8,000 new dialysis patients per year. Estimates of how many of these patients are transplant candidates range from 15% to 50%, and as results continue to improve, more will become candidates in the future. At present, neither age nor underlying disease process is considered an absolute contraindication to transplantation. For example, the diabetic patient, once thought not to be a viable candidate for transplantation, is now the leading cause for renal failure requiring kidney replacement.

A potential donor is any person who dies in circumstances such that at least one solid organ or tissue could be retrieved for transplantation purposes provided consent could be obtained. Estimates of the number of potential donors of solid perfused organs available in the United States range from 15,000 to 25,000, with most surveyors agreeing that 20,000 is close to correct. However, organs are recovered from only about 15% of this potential donor pool. This means that 34,000 kidneys, 17,000 hearts, livers, pancreata and pairs of lungs are being wasted. These organs could save lives and increase the quality of life and productivity for the majority of people now waiting on the transplant recipient roles. The pool of organs available for transplantation of all of those in need exists, but it is not being utilized at the present time.

A recent study conducted by the Gallup Organization found that 94% of all Americans have heard or read about organ or tissue transplantation.[1] However, in that survey only 48% of those aware of organ transplants were likely to want their organs to be donated at the time of their own death. Another 20% said they may or may not donate. Reasons for not donating were varied, but a most common theme was simply a failure to have given organ donation any serious consideration and thought. It simply was not a concern in their everyday lives. Clearly more education of the need for organs and the impact of transplantation should be targeted for

TABLE I
NUMBER OF TRANSPLANTS DONE IN THE UNITED STATES

	1981	1982	1983	1984	1985	1986
Heart	62	103	172	346	719	1,368
Heart/Lung					30	45
Kidney	4,885	5,358	6,112	6,968	7,800	10,566
Liver	26	62	164	308	602	924
Pancreas		35	61	87	130	130
Corneas		18,500	21,250	24,000	26,326	28,000

the general public to overcome this barrier.

It is generally agreed that the biggest obstacle to organ donation lies with health care professionals. The majority of physicians understand the effectiveness of organ transplantation and the need for post-mortem donation. Physicians rarely have philosophical objections to organ donation, but simply lack enthusiasm for presenting the subject to their own patients and families. A patient who is brain dead often represents a treatment failure. The physician may be hesitant to approach a potential donor's family because he does not wish to intrude on their grieving to ask something of them. In fact, many families would be willing to donate a deceased loved one's organs if given the opportunity. Surveys of donor families have shown numerous times that organ donation helped during the difficult grieving process, in permitting something good to come out of an untimely tragedy. It allows a family to focus on a positive process rather than a loss. Anger at not being given the option of organ donation has been expressed by some families on occasion, and a small but growing number of families have actually bypassed their physician and taken the initiative in asking whether organ donation is possible for their deceased family member. Clearly we have an adequate donor pool but a shortage of "askers."

Many physicians feel uncomfortable with the whole concept of brain death and organ recovery. It all seems so gruesome, experimental and foreign to everyday clinical practice. They have concerns about potential medicolegal problems that might arise. In fact, medicolegal problems have been extremely rare in the process of brain death and organ donation. Most states, including Kentucky, now have a brain death legislation that clearly states and documents that when all brain function has ceased, death has occurred.

The additional time and effort that is required of a busy physician also presents an obstacle to the organ retrieval process. There exists throughout the state, organ procurement personnel whose sole purpose is to facilitate this whole process and relieve the physician of much of the burden. However, the process must be initiated by the physician or other health care worker who is providing pre-mortem patient care. There needs to be a shift of attitude at some point from preserving the life of a patient who is brain dead, to preserving organ function for a recipient patient whom the physician will never know or see. There must be recognition by all physicians that care of a patient includes not only the patient himself but the patient's family, and the needs of our society.

The National Organ Transplant Act of 1984 provided for a Task Force on Organ Transplantation. This Task Force made its recommendations to Congress in April 1986.[2] The United Network for Organ Sharing (UNOS) emerged as a direct result of those recommendations of this Task Force. UNOS was awarded the contract by the Health Care Financing Administration to establish a national network to improve the effectiveness of organ donation and procurement and to increase the availability of and access to donor organs for patients with end-stage organ failure. It has a similar charge to provide for the equitable procurement and distribution of extrarenal organs. UNOS began operations in October 1987. All organ procurement agencies and transplant centers are required by law to participate in UNOS and follow the rules and guidelines established by UNOS. All regions of the country are equally represented on the board of directors of UNOS and there is a significant lay representation. UNOS has not been in existence long enough to know what impact it will have on organ procurement, but it is hoped that such a nationwide network will increase the number of donated organs through both an equitable dis-

tribution of these organs and an extensive professional education agenda. Public awareness and education still remain the obligations of the local organ procurement agencies and transplant units.

Kentucky has made progress in the last few years to increase the number of organs recovered from potential donors within the state. In 1986, House Bill 226 was passed into law and provides a definition for brain death for the state's practitioners. It lists that in cases where respiration and circulation are artificially maintained, and there is total and irreversible cessation of all brain function, then death has occurred. This determination of brain death must be made by two licensed physicians. With this bill, medicolegal considerations concerning liability in the death of a patient are eliminated. All physicians can now make the diagnosis of brain death simply on medical grounds, and the wastage of organs and added expenses of cadaver care can be avoided.

A separate piece of legislation (House Bill 5) was passed the same year which requires hospitals to develop programs for the routine inquiry for organ donation. The major components of this bill are, first that all hospitals must establish protocols which identify and encourage organ donation as a condition for hospital licensure by the State. Secondly, upon every death or terminal condition, the hospital administrator or his designee must document that the patient meets the hospital's established policy for organ donation and notify the local Organ Procurement Agency of that patient's potential. Thirdly, it exempts the family from any financial liability for costs related to the recovery of donated organs and tissues. And finally, it requires hospital personnel to make a reasonable effort to determine and communicate the intent of the patient to donate his organs.

House Bill 5 requires that the Organ Procurement Agency be notified in every death except when a medical contraindication to donation exists. Subsequent organ and tissue donation is an option which must be offered to the family; the decision of the responsible party is protected and supported by this legislation. The physician's responsibility is to identify the terminal condition or make the official pronouncement of death. The physician may or may not choose to be involved in offering the option of organ donation to the family. This task rests with the professionals within the organ procurement system and they are experienced in approaching families with these ideas and options.

The physician should be aware of the important features of the organ donor process. All solid organs (kidney, heart, liver, pancreas and lung) must be obtained from heart-beating cadavers following the pronouncement of brain death. Other organs or tissues can be recovered within eight to 12 hours after cardiac standstill and this period is extended to 24 hours if the body is refrigerated. Organ specific contraindications exist but rarely does one diseased organ prohibit the procurement of others. An absolute contraindication for all donors exists when age greater than 65, rabies, AIDS, systemic sepsis or cancer (except when the tumor is primary to the central nervous system) is present. When confusion exists concerning acceptability of a potential donor, the Organ Procurement Agency is available for consultation.

In October of 1987, Kentucky Organ Donor Affiliates, or KODA, came into existence. This is a certified independent organ procurement agency that resulted from the collaborative efforts of the existing University of Louisville and the University of Kentucky organ procurement programs. KODA has the responsibility for procurement of solid organs and tissue from all potential donors in the state of Kentucky, adjoining counties of Southern Indiana, and West Virginia. A small segment of Northern Kentucky is served by the Organ Procurement Agency out of Cincinnati. KODA is also responsible for public education about organ donation and participates in the nationwide organ sharing network of UNOS. KODA has regional offices in Louisville and Lexington, with district offices in Bowling Green, Paducah, and Ashland. Procurement professionals are available at all times to assist the physicians of Kentucky in the difficult process of asking and procuring organs and tissues. Since its inception, KODA has seen a dramatic increase in the numbers of organs and tissues procured and utilized.

Organ transplantation will continue to improve and costs will decline. All physicians need to play a more active role in the organ procurement process and help remove some of the barriers to efficient utilization of a bountiful resource that now exists within our State. The donor physician is a key starting ingredient in the transplantation process and should take pride in being an integral member of the transplantation team.

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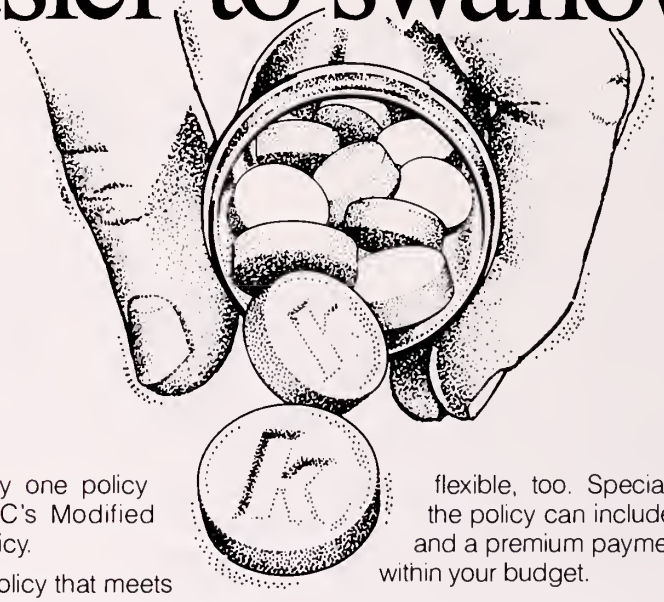


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Sidewalks

One of my pet peeves is the absence of sidewalks in most residential areas developed since World War II. This may not seem to be an appropriate subject for a medical journal, but it may be more appropriate than one would judge at first glance. After all, the safety of our citizens (especially our children) should be one of our major concerns. And certainly the ill effects on our psyches and our social well-being resulting from no sidewalks should make this a matter of some importance to all of us.

Prior to World War II, most neighborhoods had sidewalks. In the small central Kentucky town where I grew up, there were hardly any streets without sidewalks. Why don't they build sidewalks anymore? I suppose it's simply because sidewalks are an added expense which decreases the profits of the realtors. The developers have found they can get away without this expense, and they have, almost without exception, seized the opportunity to do so.

Sidewalks are wonderful things in several ways:

1. Sidewalks are safe. Walking in the street, especially busy streets, is not safe. Small children riding tricycles in the street is not safe. Jogging on busy streets is not safe and has resulted in many injuries, plus a significant number of deaths.

2. Sidewalks are sociable. They provide children a place to play hopscotch. They stimulate and encourage people to walk around their neighborhoods without the fear and aggravation of being on the constant lookout for menacing automobiles. They promote friendships between neighbors and are a sort of unifying force in a neighborhood.

3. Sidewalks promote trade and commerce. People who live near stores are likely to stroll over on leisurely shopping expeditions if there are sidewalks to stroll on. As it is now, one almost has to get in his car to go to an even nearby store because walking on the streets in such a busy area is almost impossible.

4. Sidewalks are attractive. Some may disagree with this, but I think sidewalks add to the appearance of a community in a positive way.

5. Sidewalks are healthy. They promote healthful exercise by encouraging people to go for walks. Many more of us would go for walks if we didn't have to dodge cars.

For those readers who live in the Louisville area, I will cite an example. Compare, if you will, Chenoweth Lane and Hubbards Lane, two busy suburban streets fairly near each other. Hubbards Lane has no sidewalks. It is a disaster for pedestrians. Trying to walk along it is almost out of the question. There is no reasonable way to get to nearby drugstores, grocery stores, etc, etc (many other shops), on foot. By contrast, look at Chenoweth Lane. For some reason there is a sidewalk (on one side only) along the entire length of Chenoweth Lane from St. Matthews to Brownsboro Road. That sidewalk is a godsend. It looks good. It is an immeasurable source of pleasure and satisfaction to the people living in the adjacent subdivisions. It is used prodigously by many people. It is a tremendous asset. Try to imagine how much better Hubbards Lane would be with sidewalks. The improvement would be awe-inspiring.

Maybe our Legislative Committee could sponsor a bill at the next session of the Kentucky Legislature making sidewalks mandatory in future real estate developments. What a magnificent gift that would be to future generations.

McHenry S. Brewer, MD

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The Foundation of the Jefferson County Medical Society

Arthur H. Keeney, MD, DSc

Dr Keeney serves as President of The Foundation of the Jefferson County Medical Society.

The Foundation of the Jefferson County Medical Society was created as a 501(c)3 organization in 1958 under the leadership of the late Sam A. Overstreet, MD. In dedication to the public weal, its first usefulness came through the 1962-63 Sabin Oral Sunday polio immunization program which reached over 90% of the population in the metropolitan service area of Louisville. Voluntary contributions, shared with Junior Chamber of Commerce co-workers, enabled the Foundation to make major grants to the Child Guidance Clinic and the Children's Hospital Foundation. The Foundation has also continued annual contributions to the Kornhauser Medical Library, following merger of the County Medical Society Library with the School of Medicine Library in 1921. The Foundation continues an annual program of medical student emergency loans without interest.

The crowning achievement of the Foundation, however, was catalyzed by a UofL trustee decision to sell the old schoolhouse at First and Chestnut Streets. The University and urban planners had pronounced it totally useless. The Louisville School Board negotiated to buy it and destroy the building for a parking lot. Though the building had been empty since 1970 when the School moved to its new quadrangle, the old guard rose in fiery reaction from August 1976 to May 1977 to acquire the building. Almost every room evoked enormous personal pull for Charles Smith, Robert Howell, Sam Weakley, Sam Overstreet, Si Auerbach and hundreds of other graduates. Through clever capital financing worked out by Carl L. Wedekind, the Foundation acquired title to every stone, leaking window and the peeling plaster. With unrealized foresight, Charles C. Smith, MD, former KMA president, appointed the ingenious Richard Wolf, MD, as construction manager. A few transients were removed from their squatters sites, and fund raising began in earnest. Physicians, friends, societies and foundations ultimately met the entire remodeling cost of $3,475,000 for 73,000 square feet of building. The new slate roof, copper downspouts, double-glazed windows, repaired plaster, and the heating, lighting and air conditioning were all completed at a cost of about $47 per square foot.

The mission of the building is to provide a home for medically oriented organizations not involved with direct patient flow into the premises. Major tenants now are the Visiting Nurses Association, the Ronald McDonald House, and the Jefferson County Medical Society. Smaller spaces have been provided for the Kentucky Diabetes Association, Hospice, and the Department of Medicine educational offices. Meeting rooms, reception facilities, and kitchens are rented for many professional and social gatherings. Today the building, operating in the black, stands productive in meeting many support needs of medicine.

Last year, 623 physicians, graduates and nongraduates of the school, voluntarily were annual financial supporters. A small contingency fund has been created for repairs and charitable activities. The 17-member Foundation Board meets once a month and continues to support medically related projects such as the Health Awareness Week for freshmen medical students, high school Science Fairs and the Consortium for Continuing Medical Education. An oral history project has been consummated. This past year the third of its annual Medical History Series was presented as an afternoon and dinner meeting on November 14, beginning at 3 PM. History and progress live in the five stories of the stone building. Understanding of the problems of today is enhanced by appreciation of the many problems and advances which antedate us. Today the solvent and vital utilization of a building which meant so much to approximately 8,000 medical practitioners of Kentucky and the nation is a testimonial to bonds of compassion and respect.



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AKMA — Our Pride is Showing



The Auxiliary to the Kentucky Medical Association has established a proud reputation for service and support to the Kentucky Medical Association. Programs initiated by county auxilians have brought local and national awareness to numerous health issues.

Funds raised by auxilians are most impressive. Since 1975, almost $376,000 has been contributed to AMA-ERF. One dollar from each state member's dues is allotted to the Allied Health Careers Fund, and to date, over $78,000 has been loaned to Kentucky students pursuing a career in the allied health fields. This year the loan fund has become a grant for deserving students. The Auxiliary has always loved and valued the McDowell House and has given over $32,000 to the refurbishing fund, $16,000 to the Brown Challenge Grant, and countless gifts of furniture and books since 1982.

There is, however, more to the Auxiliary than its effective fund raising. Results of an AKMA membership survey showed great concern for malpractice litigation and legislation. In response, a seminar will be held at the KMA Convention featuring Susan Bryant, a Washington, DC, political consultant. The topic will be "The Time to Get Involved is Now," and all KMA and AKMA members are encouraged to attend.

The Auxiliary continuously strives to meet the needs of all physician spouses by providing support systems and social camaraderie. The National and State Auxiliaries provide effective training for leadership development. Available to all county auxiliaries is the *Project Bank* which provides an enormous supply of successful health projects developed nationwide.

The Auxiliary is proud to be a support system for the Kentucky Medical Association. It takes great pride in its accomplishments in the past and looks forward to new challenges. The members are proud of their physician spouses who are dedicated to better health care for their patients.

Carol Franks
AKMA President

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Yohimbine exerts a stimulating action on the mood and may increase anxiety. Such actions have not been adequately studied or related to dosage although they appear to require high doses of the drug. Yohimbine has a mild anti-diuretic action, probably via stimulation of hypothalmic centers and release of posterior pituitary hormone.

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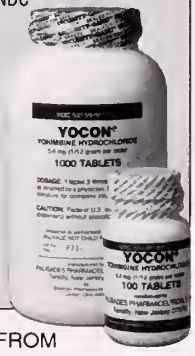
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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"THE BUSINESS OF MEDICINE IS OUR BUSINESS"

To the Editor:

Re: Sympathetic block an adjunct for treatment

Twenty-six cases of copperhead snakebite, reported to the Kentucky Regional Poison Center in 1986, were analyzed to emphasize points in diagnosis and initial treatment by Dr. Bruce David White and colleagues in the *Journal* (p. 61, Feb. 88). The epidemiology is of interest. The regional sympathetic ganglion anesthesia as a treatment adjunct is the reason for this letter.

Before retirement in January 1986, sympathetic ganglion and post-ganglionic adrenergic nerve blocks had been integrated into my training in New Orleans and into my practice for 40 years.

I used sympathetic blocks in two cases of copperhead snakebite in the 1960s. Both cases had a painful edematous blanched lower extremity and were immobilized by pain. Both were treated with 1% procaine lumbar sympathetic ganglion blocks (L2, 3, 4) with relief of major pain by the method. This was repeated in 36 or 48 hours because of a pain recurrence. They could walk comfortably. The warm packs were continued intermittently. The edema was improved and slowly subsided with short-term residual traces.

Vasoactive substances with a relatively short one-half life of 15 seconds, such as bradykinin appear to be banished from the area by relief of the bradykinin induced small vessel spasm, in turn permitting passively an increased blood flow by the sympathetic ganglion block.

The phospholipid A factors usually associated with copperhead snakebites, and probably other species, could be the repetitive source of bradykinin activated by the internal coagulation patho-pharmacology system change through enzyme cascades and Blood Factor XII.

The return of pain in these two cases would then require the second ganglion block with 1% procaine for pain relief and continuation of the edema subsidence. This is a change from what I found in acute pancreatitis pain and edema where only one early sympathetic ganglion (celiac) block was required to abort the attack, clinically and experimentally.

More toxic envenomation could require more selective consideration of antivenin, in spite of risks of anaphylactoid reactions and serum sickness. Early debridement in these situations to remove the pit viper envenom load would aid in preventing more serious systemic effects and more complications of the internal body coagulation system.

John B. Floyd, Jr, MD
Lexington, KY

To the Editor:

The seal of the state of Kentucky is a good motto for any organization — that is, united we stand, divided we fall.

The chiropractors and optometrists of Kentucky and other states have made great success and financial gains because they were 100% united, or near that. They supported the politicians in the state legislature, and they got what they paid for.

Our success since malpractice insurance became a problem has been limited because of lack of interest of many members who pay token, or very small, insurance premiums. I feel that over all, our interest in these matters will pick up as our premiums, over all, increase.

Many hospital medical staffs have been snookered by hospital boards and administrations into increasing their coverage to one million. This is fatal because next year, or soon, they will want a million and a quarter and more and more. The hospitals need to provide their own deep pocket.

Clifton E. Lowry, MD
Owensboro, KY



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Memoir of R.W. Robertson 1903-1988



by Wally O. Montgomery, MD

The community and medical profession were markedly diminished by the loss of Robert Wintersmith Robertson, MD, of Paducah, Kentucky, on March 9, 1988.

Doctor Robertson was a proud graduate of Centre College, class of 1925, and Loyola of Chicago Medical School in 1931. He began his medical practice in Paducah in 1933.

Doctor Robertson joined the Army Medical Corps in World War II. Assigned to British forces at Anzio, Italy, in 1944, he performed more than 500 operations on British troops. For this service he was awarded the Order of the British Empire and the American Bronze Star.

Doctor Robertson was president of the Kentucky Medical Association in 1958-1959 and founding board member of Kentucky Blue Cross & Blue Shield insurance company. He was a member of numerous American and international surgical societies including ACS, Kentucky Surgeons, Southern Surgical, Southeastern, The British Royal Society of Medicine and the Royal College of Surgeons.

He was actively involved in his community serving the First Presbyterian Church as an elder and also as a member of the Paducah Rotary Club.

Our sympathies are extended to his wife Helen; a daughter, Lucy O'Mara of Needham, Massachusetts; three sons, Dr. Robert W. Robertson, Jr. of Paducah, Dr. George W. Robertson of Louisville, and William Howard Robertson of Keene, New Hampshire.

Doctor Robertson will be sorely missed by his colleagues, community, and those countless friends he made around the world.

A Dream

As your new KEMPAC Board Chairman, I hope to boost along a dream I have had for many years. It has had a bumpy, rocky, turbulent course through the local Jefferson County Legislative Committee and State and National KMA Legislative Committees, as well as a prior term on the KEMPAC Board. The steps now seem rather clear.



Phase One

Might as well take the easiest first. All of our KMA Officers, Delegates and Alternate Delegates to the AMA, and Board of Trustee Members will be sustaining members of KEMPAC. As of now, we are only six short of a 32 total. This is just a matter of a little time and effort. This part of the dream will soon be fact.

Phase Two

All of our KMA Delegates, come September and our State Meeting in Lexington, will be proudly wearing that KEMPAC ribbon on their badge. This will indeed be a very warm, unifying sight and maybe a tad difficult feat.

Phase Three

KMA had 5,292 members in 1987. Our present count in KEMPAC is approaching the 800 figure. In 1987, our count was 855, including 795 Sustaining members; the latter being the best ever. Because of this, we got in many good strokes during the just past session of the State Legislature.

KEMPAC has contributed $88,000.00 to State candidates for the 1988 elections. With such a combined effort as this, we will be heard.

Our goal for 1988 is 1,150 members. The Membership Committee is Charles Allnutt, MD, of Lakeside Park, Charles Moore, MD, of Middlesboro, and a member of the Auxiliary to KMA, to be named.

A special bow to Pulaski County where 100% of the KMA Membership has contributed to KEMPAC for '88.

Phase Four

I see ever increasing help and work with our excellent Auxiliary to KMA. As a long-standing member of this auspicious group, I have learned to appreciate them greatly and recognize their splendid potential. The Auxiliary contribution during the recent Legislative Session was quite notable.

Phase Five

Every "key person" will be active throughout the entire year. Contacts with his or her Legislator will be made regularly. No task will be too menial. We will assist in some way with each race and/or help with plans for the next race.

Each "key person" will be especially sure that his or her Legislator is invited to our Twenty-Sixth KEMPAC Seminar Banquet. This will be held on Monday evening, September 26, 1988, at the Hyatt Regency Hotel in Lexington. Our guests will have many friends in attendance.

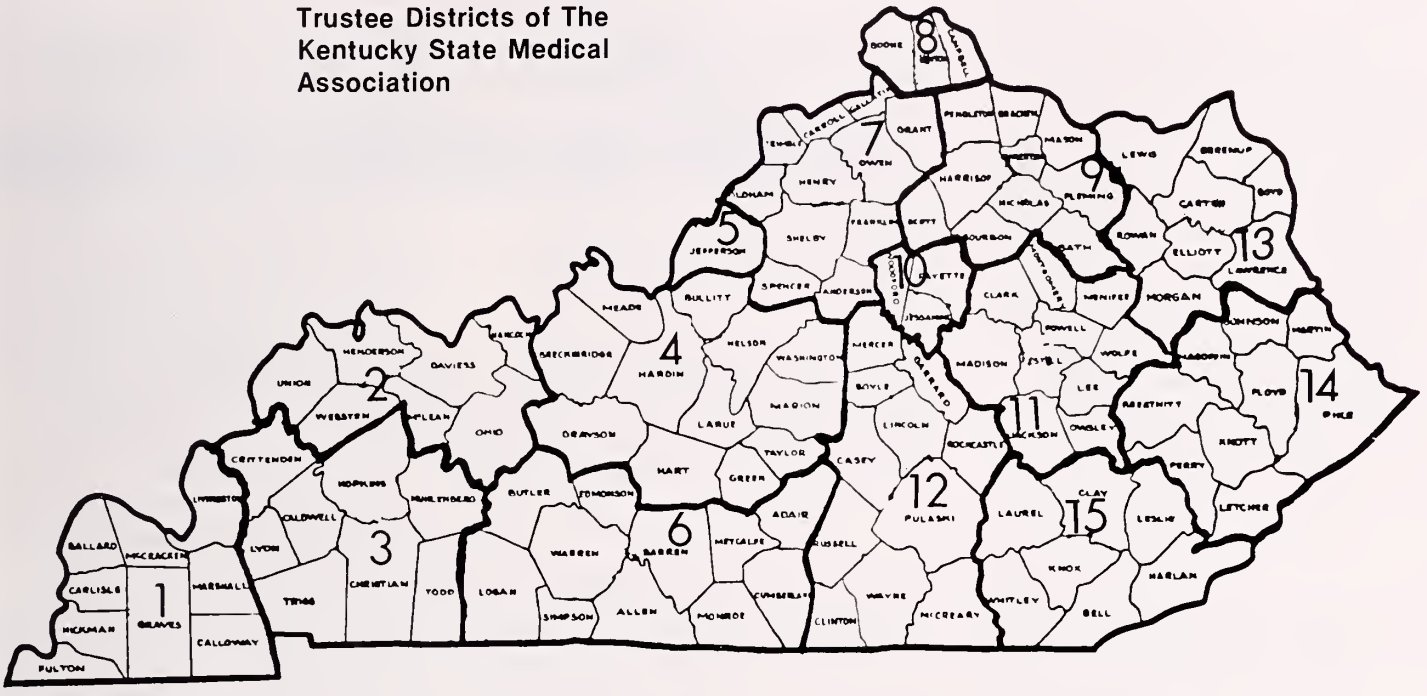
Susan Bryant, President of Research/Strategy/Management, Inc, a Washington-based political consulting firm, will be our featured speaker. She has a national reputation of being excellent.

Conclusion

I hope that there are a lot of other dreamers and especially doers out there. I plan to do some bonafide bragging come '89.

Sam D. Weakley, MD
KEMPAC Chairman

Trustee Districts of The Kentucky State Medical Association



KEMPAC First Quarter Membership Report

KMA Trustee Districts — Percentage of KMA members, members of KEMPAC

First	27%	Sixth	9%	Eleventh	2%
Second	25%	Seventh	8%	Twelfth	19%
Third	33%	Eighth	7%	Thirteenth	19%
Fourth	15%	Ninth	5%	Fourteenth	22%
Fifth	15%	Tenth	21%	Fifteenth	9%

Counties with 100% KMA Delegates members of KEMPAC are Boyle, Breckinridge, Edmonson, Elliott, Hopkins, Livingston, Mason, Ohio, Trimble, Washington.

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A portion of voluntary political contributions will be used in connection with Federal elections and are subject to the prohibitions and limitations of the Federal Election Campaign Act. Contributions are not tax deductible.

Nominations Being Accepted for Three Annual KMA Awards

Nominations are being accepted for three awards which are presented each year at the KMA Annual Meeting to outstanding physicians and lay people.

The Distinguished Service Award is presented each year to a physician in the state who has contributed to organized medicine or individual medical service, community health or civic betterment and medical research or distinguished voluntary military service. The nominee may qualify on any one or a combination of these points.

The Kentucky Medical Association Award is presented to an outstanding lay person in honor of his or her outstanding accomplishments in the field of public health and/or medical care. Recipients of the Distinguished Service Award and the Kentucky Medical Association Award will be chosen by the Awards Committee. **July 15** is the deadline for receiving nominations for these awards.

Nominees for the Educational Achievement Award are chosen from citizens of the Commonwealth of Kentucky who have made a significant contribution in medical or medically related education. Contributions in all areas of teaching, research, clinical application of medical practice and/or patient education are factors that will be considered. Recipients are chosen by the Continuing Medical Education Committee. **July 1** is the deadline for receiving nominations for the Educational Achievement Award.

Nominee material should include background and historical information about the nominee as well as justification for the nomination.

KMA-HMSS Annual Meeting Scheduled for June

The KMA Hospital Medical Staff Section will hold its annual meeting at the Kentucky Medical Association on Thursday, June 16, 1988, beginning at 1:00 PM and concluding around 3:30 PM, EDT.

The program will include presentations on:

- **Quality Assurance — a New Imperative** to include information on the Health Care Quality Improvement Act (P.L. 99-660); quality assurance activities of the Joint Commission on Accreditation of Hospitals; activities of the Health Care Financing Administration in releasing Medicare hospital mortality data — James S. Todd, MD, Senior Deputy Executive Vice President of the American Medical Association.
- **Relative Value Scales** — Russell L. Travis, MD, Lexington, KMA Delegate to the American Medical Association, Chairman of the Kentucky Physicians Care Operating Committee.
- **AIDS** — Ardis Hoven, MD, Lexington, Chairman, 1986-87 KMA Ad Hoc Committee on the Development of AIDS Guidelines.
- **The Kentucky General Assembly and Tort Reform - 1988** — Wally O. Montgomery, MD, Paducah, Chairman of KMA's Committee on State Legislative Activities and the Ad Hoc Committee on Professional Liability Insurance.
- **Business Meeting** and **Election of Steering Committee Members**

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Tuesday, June 7, 1988
Morning Session
Theme *Pediatric Emergencies*
Mary Queen of Scots Ballroom

8:00 AM	Registration
8:40 AM	Welcome and Orientation Opening Remarks E.T. Mays, MD, Somerset, Chairman, KMA Emergency Medical Care Seminar Committee Moderator: William A. Wetter, III, Louisville
9:00 AM	*Immediate Pediatric Management:* *The Trauma Team* Mary E. Fallat, MD, Louisville
10:00 AM	**Coffee Break**
10:20 AM	*Heat Illness* Daniel F. Danzl, MD, Louisville
11:00 AM	*Acute Asthma in Children* Mary A. Smith, MD, Louisville
11:20 AM	*EMS Statement of Direction* Bob Kellow, Texas
12:00 noon	**Luncheon**—Queen of Scots Room **Guest Luncheon Speaker** *What's Killing Our Children* John C. Hunsaker, MD, Lexington

Tuesday, June 7, 1988
Afternoon Session
Track I *Paramedics and EMT's*
Moderator:
Tommy Thompson, Frankfort
Loch-Heather Room

2:00 PM	*Pediatric Neurological Emergencies* Ralph M. Garvin, EMT Instructor/ Paramedic, Ashland
2:30 PM	*Emergency Pediatric Assessment* (The difference between pediatric and adult) Ann B. Reeser, EMT Instructor, Elizabethtown
3:00 PM	**Dessert Break**
3:15 PM	*Juvenile Diabetes* Mike Bouvier, EMT Instructor, Owensboro
4:15 PM	Adjournment
4:30 PM	Ambulance Competition (Everyone Welcome to Observe Competition)

Tuesday, June 7, 1988
Afternoon Session
Track II *Emergency Medicine*
(physicians/nurses)
Moderator:
Barbara Cox, RN, Louisville
William Room

2:00 PM	*Neurologic Emergencies* Russell L. Travis, MD, Lexington
3:00 PM	**Dessert Break**
3:15 PM	*Neurologic Emergencies* Russell L. Travis, MD, Lexington
4:15 PM	Adjournment

Tuesday, June 7, 1988
Afternoon Session
Track III *Operating*
(physicians/nurses)
Moderator:
Linda Marsh, RN, Shepherdsville
King Room

2:00 PM	*Foreign Body Ingestion and* *Aspiration in Children* Diller B. Groff, MD, Louisville
3:00 PM	**Dessert Break**
3:15 PM	*Orthopedic Emergencies* Edward D. Tillett, MD, Louisville
4:15 PM	Adjournment

Tuesday, June 7, 1988
Afternoon Session
Track IV *Emergency Medicine*
(physicians/nurses)
Moderator:
Donald Thomas, MD, Louisville
The Lion Room

2:00 PM	*Pediatric Trauma* Mary E. Fallat, MD, Louisville
3:00 PM	**Dessert Break**
3:15 PM	*Pre Hospital Emergency Care* Daniel J. O'Brien, MD, Louisville
3:45 PM	*The Alcoholic Emergency Patient-* *Pitfalls and Complicating Illness* Frank W. Lavoie, MD, Louisville
4:15 PM	Adjournment

Wednesday, June 8, 1988
Morning Session
Theme *Medical Neurologic Emergencies*
Mary Queen of Scots Ballroom

8:00 AM	Registration
8:40 AM	Opening Remarks Moderator: Nelson B. Rue, MD Bowling Green
9:00 AM	*Convulsive Disorders* Andrievs Dzenitis, MD, Louisville
10:00 AM	**Coffee Break**
10:20 AM	*Headaches* Carrie A. McCoy, RN, MSN, CEN, Covington
10:40 AM	*Stupor and Coma* Joseph M. Vetter, EMT Instructor/ Paramedic, Louisville
11:00 AM	*Rapid Neurologic Assessment* Chris Bidwell, RN, BSN, CEN, Louisville
11:35 AM	*Stroke Diagnosis and Treatment* Billy R. Miller, EMT Instructor/ Paramedic, Somerset
12:00 noon	**Luncheon** — Queen of Scots Room **Guest Luncheon Speaker** *Dealing with Violent and Abusive Patients* Frank W. Lavoie, MD, Louisville

Wednesday, June 8, 1988
Afternoon Session
Track I *EMT's and Paramedics*
Moderator:
Tommy Thompson, Frankfort
Loch-Heather Room

2:00 PM	**Panel Discussion** *EMS — Can a "team" effort make a difference?* Robert E. Young, MD, Morehead Samuel D. Fritz, MD, Richmond Keith McCormick, JD, Morehead David S. Ross, MD, Florence
3:00 PM	**Dessert Break**
3:15 PM	*Law for EMT's and Paramedics — Where to take the Patient* Keith McCormick, JD, Morehead
4:00 PM	Questions and Answers
4:15 PM	Adjournment

Wednesday, June 8, 1988
Afternoon Session
Track II *Emergency Medicine*
(physicians/nurses)
Moderator:
Barbara Cox, RN, Louisville
William Room

2:00 PM	*Mechanisms and Patterns of Trauma* Judy Stoner Halpern, RN, MS, CCRN, Michigan
3:00 PM	**Dessert Break**
3:15 PM	*HIV Infection — Hepatitis B — Risk to Health Care Workers?* Janet B. Sergent, RN, Louisville
4:15 PM	Adjournment

Wednesday, June 8, 1988
Afternoon Session
Track III *Operating*
(physicians/nurses)
Moderator:
Linda Marsh, RN, Shepherdsville
King Room

2:00 PM	*Stabilization and Transportation of the patient with a leaking aneurysm* William C. DeVries, MD, Louisville
3:00 PM	**Break**
3:15 PM	*Blunt Trauma to the Abdomen* Frank B. Miller, MD, Louisville
4:15 PM	Adjournment

Wednesday, June 8, 1988
Afternoon Session
Track IV *Emergency Physicians*
Moderator:
Donald Thomas, MD, Louisville
The Lion Room

2:00 PM	*Aeromedical Transportation — past, present, and future* Gary L. Carter, MD, Cincinnati
3:00 PM	**Dessert Break**
3:15 PM	*Update on Federal EMS and Trauma Legislation* Bob Kellow, Texas
4:15 PM	Adjournment
4:30 PM	Open Meeting: Kentucky Emergency Nurses Association
4:30 PM	Open Meeting: Kentucky Chapter, American College of Emergency Physicians

Thursday, June 9, 1988
Morning Session
Mary Queen of Scots Ballroom

8:00 AM	Registration
8:40 AM	Opening Remarks Moderator: Suzanne Bass, RN Hopkinsville
9:00 AM	*Acute Respiratory Insufficiency* Barbara Phillips, MD, Lexington
9:20 AM	*Facial Trauma* Patricia A. Sturt, RN, CEN, Lexington
10:00 AM	**Coffee Break**
10:20 AM	*Is Menopause Really Necessary?* Charles R. Oberst, MD, Louisville
11:20 AM	*Dental Emergencies* Keith L. Ray, DMD, Louisville
12:00 noon	**Luncheon** — Queen of Scots Room **Guest Luncheon Speaker** *Working Together for Improved Trauma Care* Judy Stoner Halpern, RN, MS, CCRN, Michigan

Optional Program

2:00 PM	*Locus of Control — Handling Emergency Patients* Helen Jean Coleman Wiese, PhD, Lexington

What's new in Cancer Therapy

September 27-29
Hyatt Regency Lexington/Lexington Convention Center
Lexington, Kentucky

Scientific Sessions

The Hyatt Regency Lexington/ Lexington Convention Center will host the 1988 Annual Meeting. The Scientific Program Committee has invited speakers from across the nation to participate in the sessions to be held during the mornings of September 27, 28 and 29. The program scheduled for Wednesday will feature William C. DeVries, MD, Humana Hospital Audubon; Russel Patterson, MD, Vice Chairman, Ethics & Judicial Council, AMA; and Andrew Malcolm, First Assistant National Editor, *New York Times*, speaking on, "The Ethics of Death and Dying." Following their presentations will be a question and answer session.

Specialty Groups

Programs for 21 specialty groups will be held during the afternoons of September 27, 28 and 29. No general sessions are scheduled during the specialty group meetings and all KMA members are invited. Scientific sessions and specialty group meetings will be held in the Hyatt Regency Lexington/Lexington Convention Center. By completing CME sign-up sheets at the beginning of each meeting, physicians attending general sessions and specialty group meetings will qualify for Category 1 Credit.

KMA House of Delegates

The opening meeting of the House of Delegates will be held Monday, September 26, at 9 AM in the Hyatt Regency Ballroom, located in the Hyatt Regency Lexington. Reference committee meetings will begin at 2 PM on Monday and the final meeting of the House will begin at 6 PM Wednesday, September 28. Officers for the 1988-89 Associational year will be elected during the final House meeting.

Other Activities

The 26th Annual KEMPAC Seminar will be held Monday evening, September 26, at the Hyatt Regency Lexington. A reception begins at 6 PM with dinner at 7 PM, and the program to follow at 8 PM. Susan Bryant, President of Research/ Strategy/Management, Inc., based in Washington, DC, will be the featured speaker.

The President's Luncheon will be held September 28, with presentations of KMA awards and the installation of the 1988-89 KMA President, Bob M. DeWeese, MD. Featured speaker for the luncheon will be the Honorable Brereton C. Jones, Kentucky's Lieutenant Governor.

Scientific and Technical Exhibits will be on display featuring new medical products, services, and techniques. Members and guests have an opportunity to visit this area during the 30-minute intermissions scheduled throughout the general sessions and specialty group meetings.

Kentucky's Lieutenant Governor, the Honorable Brereton C. Jones, will be the guest speaker at this year's President's Luncheon.



C L A S S I F I E D S

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

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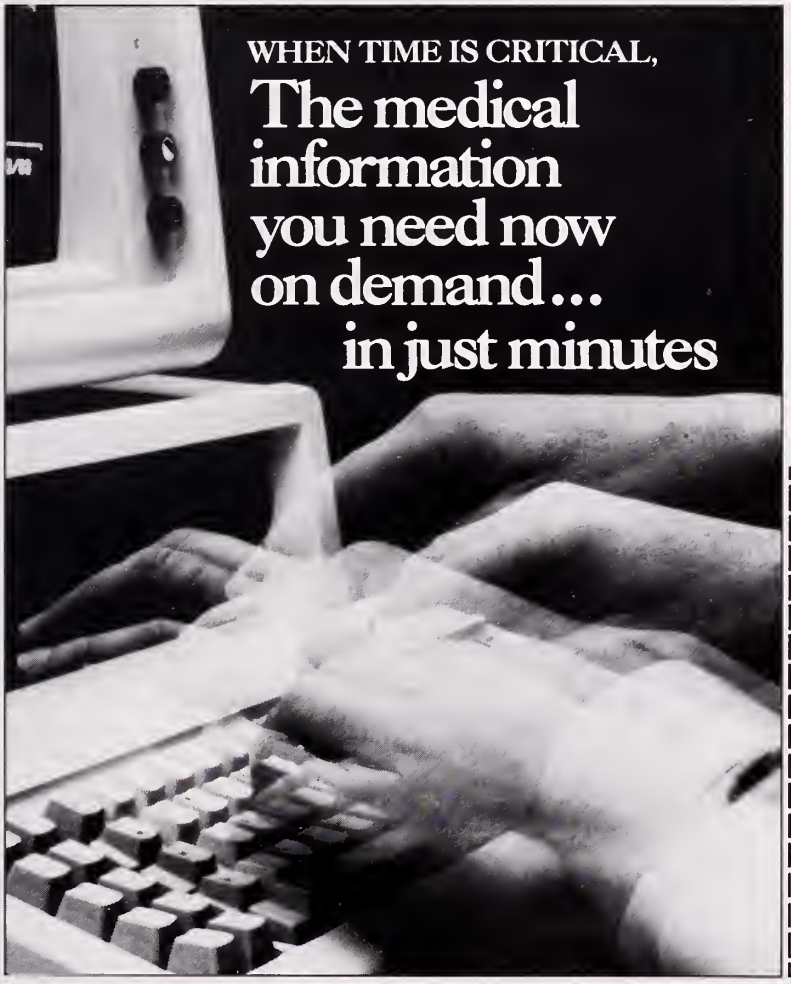
May 9-13
Diabetes In-Depth Training Workshop, Lexington, KY. 39 CEUs, $350 (daily rates also available). One week training program in diabetes, effective patient teaching, and setting up a diabetes program. Contact: Paula Gentry, 120 N Eagle Creek Dr, #321, Lexington, KY, (606) 263-5032.

May 22-27
Nineteenth Family Medicine Review — Session II — Hyatt Regency Hotel, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, University of Kentucky, Lexington, KY 40536-0086, (606) 233-5161.

June 16-18
The 33rd Annual Great Smoky Mountain Pediatric Seminar at the Park Vista Hotel, Gatlinburg, TN. Sponsored by University of Tennessee Medical Center at Knoxville, College of Medicine, Department of Pediatrics, and Knoxville Area Pediatric Society. Contact: Dr Sandra Loucks, University of Tennessee Medical Center, Dept of Pediatrics, 1924 Alcoa Hwy, Knoxville, TN 37920, (615) 544-9331.

September 3-5
Fourth Annual Multispecialty Oculoplastic Surgery Symposium, Lexington Marriott Resort, Lexington, KY. Contact: Jennifer DePrima Richard, Ophthalmology Center, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509, (606) 268-3754.

October 12-13
Care of the Seriously Ill Child — The 16th Annual Fall Pediatric Surgery/Pediatrics Symposium concerning "Acute Pediatric Emergencies," Lincoln Hotel and University Conference Center, Indianapolis, IN. Sponsored by the Indiana University School of Medicine. Contact: Jay L. Grosfeld, MD, (Symposium Director) Surgeon-in-Chief, Riley Hospital, 702 Barnhill Dr, Indianapolis, IN 46223, (317) 274-8353.



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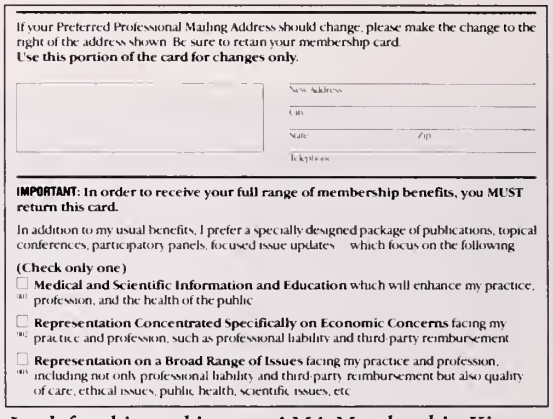
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Before prescribing, see complete prescribing information in SK&F LAB CO. literature or PDR. The following is a brief summary.

Contraindications: There are no known contraindications to the use of 'Tagamet'.

Precautions: While a weak antiandrogenic effect has been demonstrated in animals, 'Tagamet' has been shown to have no effect on spermatogenesis, sperm count, motility, morphology or in vitro fertilizing capacity in humans.

In a 24-month toxicity study in rats at dose levels approximately 9 to 56 times the recommended human dose, benign Leydig cell tumors were seen. These were common in both the treated and control groups, and the incidence became significantly higher only in the aged rats receiving 'Tagamet'.

Rare instances of cardiac arrhythmias and hypotension have been reported following the rapid administration of 'Tagamet' HCl [brand of cimetidine hydrochloride] injection by intravenous bolus.

Symptomatic response to 'Tagamet' therapy does not preclude the presence of a gastric malignancy. There have been rare reports of transient healing of gastric ulcers despite subsequently documented malignancy.

Reversible confusional states have been reported on occasion, predominantly in severely ill patients.

'Tagamet' has been reported to reduce the hepatic metabolism of warfarin-type anticoagulants, phenytoin, propranolol, chlordiazepoxide, diazepam, lidocaine, theophylline and metronidazole. Clinically significant effects have been reported with the warfarin anticoagulants; therefore, close monitoring of prothrombin time is recommended, and adjustment of the anticoagulant dose may be necessary when 'Tagamet' is administered concomitantly. Interaction with phenytoin, lidocaine and theophylline has also been reported to produce adverse clinical effects.

However, a crossover study in healthy subjects receiving either 'Tagamet' 300 mg. q.i.d. or 800 mg. h.s. concomitantly with a 300 mg. b.i.d. dosage of theophylline [Theo-Dur®, Key Pharmaceuticals, Inc.], demonstrated less alteration in steady-state theophylline peak serum levels with the 800 mg. h.s. regimen, particularly in subjects aged 54 years and older. Data beyond ten days are not available. [Note: All patients receiving theophylline should be monitored appropriately, regardless of concomitant drug therapy.]

Lack of experience to date precludes recommending 'Tagamet' for use in pregnant patients, women of childbearing potential, nursing mothers or children under 16 unless anticipated benefits outweigh potential risks; generally, nursing should not be undertaken in patients taking the drug since cimetidine is secreted in human milk.

Adverse Reactions: Diarrhea, dizziness, somnolence, headache, rash. Reversible arthralgia, myalgia and exacerbation of joint symptoms in patients with preexisting arthritis have been reported. Reversible confusional states [e.g., mental confusion, agitation, psychosis, depression, anxiety, hallucinations, disorientation], predominantly in severely ill patients, have been reported. Gynecomastia and reversible impotence in patients with pathological hypersecretory disorders receiving 'Tagamet', particularly in high doses, for at least 12 months, have been reported. Reversible alopecia has been reported very rarely. Decreased white blood cell counts in 'Tagamet'-treated patients [approximately 1 per 100,000 patients], including agranulocytosis [approximately 3 per million patients], have been reported, including a few reports of recurrence on rechallenge. Most of these reports were in patients who had serious concomitant illnesses and received drugs and/or treatment known to produce neutropenia. Thrombocytopenia [approximately 3 per million patients] and a few cases of aplastic anemia have also been reported. Increased serum transaminase and creatinine, as well as rare cases of fever, interstitial nephritis, urinary retention, pancreatitis and allergic reactions, including hypersensitivity vasculitis, have been reported. Reversible adverse hepatic effects, cholestatic or mixed cholestatic-hepatocellular in nature, have been reported rarely. Because of the predominance of cholestatic features, severe parenchymal injury is considered highly unlikely. A single case of biopsy-proven periportal hepatic fibrosis in a patient receiving 'Tagamet' has been reported.

How Supplied: Tablets: 200 mg. tablets in bottles of 100; 300 mg. tablets in bottles of 100 and Single Unit Packages of 100 [intended for institutional use only]; 400 mg. tablets in bottles of 60 and Single Unit Packages of 100 [intended for institutional use only], and 800 mg. Tiltab® tablets in bottles of 30 and Single Unit Packages of 100 [intended for institutional use only].

Liquid: 300 mg./5 ml., in 8 fl. oz. [237 ml.] amber glass bottles and in single-dose units [300 mg./5 ml.], in packages of 10 [intended for institutional use only].

Injection:
Vials: 300 mg./2 ml. in single-dose vials, in packages of 10 and 30, and in 8 ml. multiple-dose vials, in packages of 10 and 25.

Prefilled Syringes: 300 mg./2 ml. in single-dose prefilled disposable syringes.

Plastic Containers: 300 mg. in 50 ml. of 0.9% Sodium Chloride in single-dose plastic containers, in packages of 4 units. No preservative has been added.

ADD-Vantage®* Vials: 300 mg./2 ml. in single-dose, ADD-Vantage® Vials, in packages of 25.

Exposure of the premixed product to excessive heat should be avoided. It is recommended the product be stored at controlled room temperature. Brief exposure up to 40°C does not adversely affect the premixed product.

'Tagamet' HCl [brand of cimetidine hydrochloride] injection premixed in single-dose plastic containers is manufactured for SK&F Lab Co. by Travenol Laboratories, Inc., Deerfield, IL 60015.

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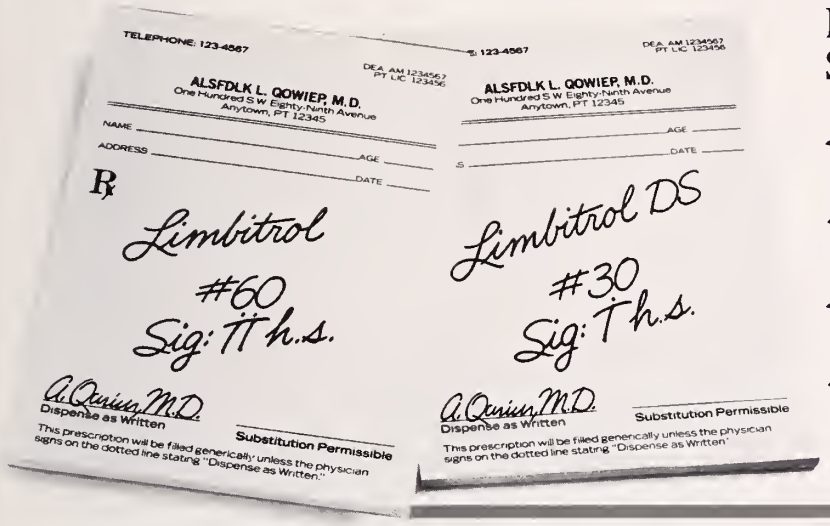
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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

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Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy*: Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.
Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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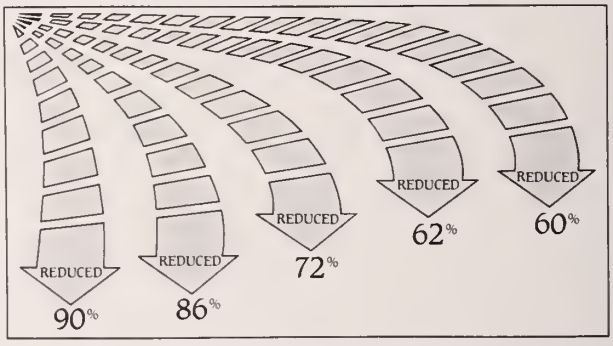
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- First-week reduction in somatic symptoms[1]

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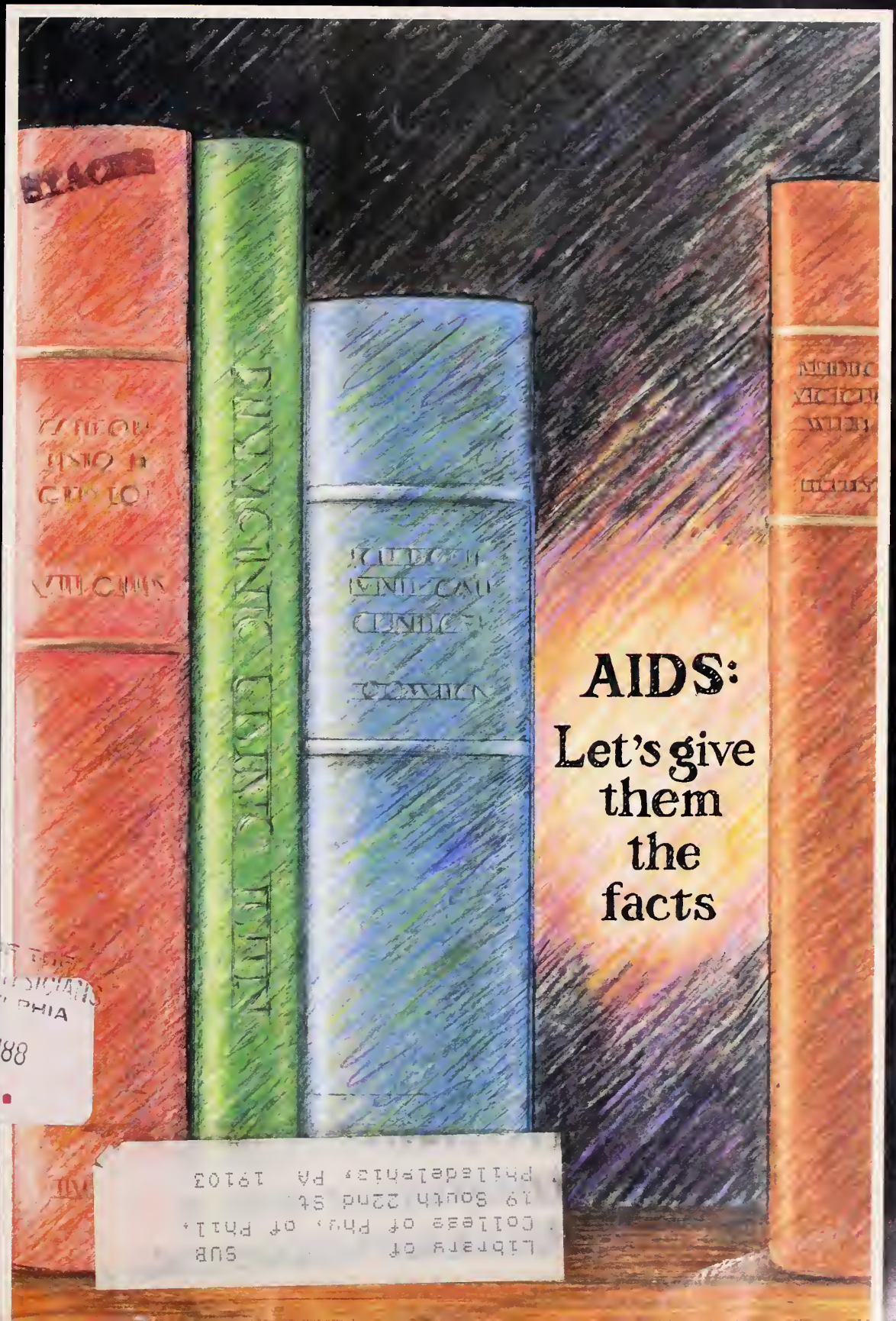
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TABLE OF

CONTENTS

June 1988

Cover:
Original cover art by Linda Fortwengler of Louisville introduces a special section on AIDS facts beginning on page 311.

SCIENTIFIC

Pancreatitis Following Aneurysmectomy
David W. Victor, Jr, MD; Joseph L. Rayburn, MD; Robert A. McCready, MD; Gordon L. Hyde, MD **285**

Automatic Implantable Cardioverter Defibrillator
Igor Singer, MBBS, FRACP; Mary Rademaker, BSc; David Slater, MD; Joel Kupersmith, MD **289**

Foregoing Life-Sustaining Procedures:
Survey and Analysis of Kentuckians' Opinions
Dallas M. High, PhD **293**

EDITORIAL

It's Only Over for Debbie **301**

ASSOCIATION

1988 Membership Phonathons Net Renewals and New Members **308**
KMA Night on KET **310**
"Let's Give America the Facts" — AIDS Primer **311**
Annual Meeting Preview **335**

REGULAR FEATURES

President's Page **281**
CME **337**
Classified **337**
Information for Authors **306**
In Memoriam **303**

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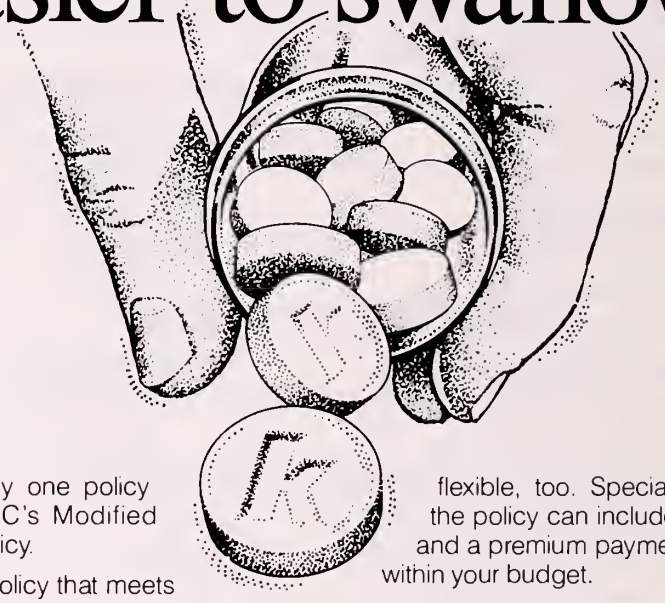
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Campbell Laboratories, Inc. 300
Charleston Area Medical Center 299
Classified 337
Differential Advantage, Ltd. 305
Elcomp Systems, Inc. 304
KMA Insurance Agency, Inc. 302, 307
KMIC 276
KMIC Investment Company 336
KMIC Leasing Company 272
Key Pharmaceuticals 305-306
Eli Lilly & Company 339
Medical Protective Company 283
Miles Pharmaceuticals 297-298
PIE Mutual Insurance Company 296
Roche Laboratories 340-342
Skycare, Inc. 300
U.S. Air Force 338
U.S. Army Reserve....284
Wyeth-Ayerst Laboratories 277-280

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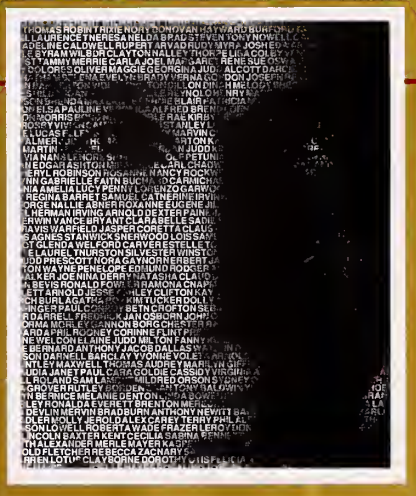
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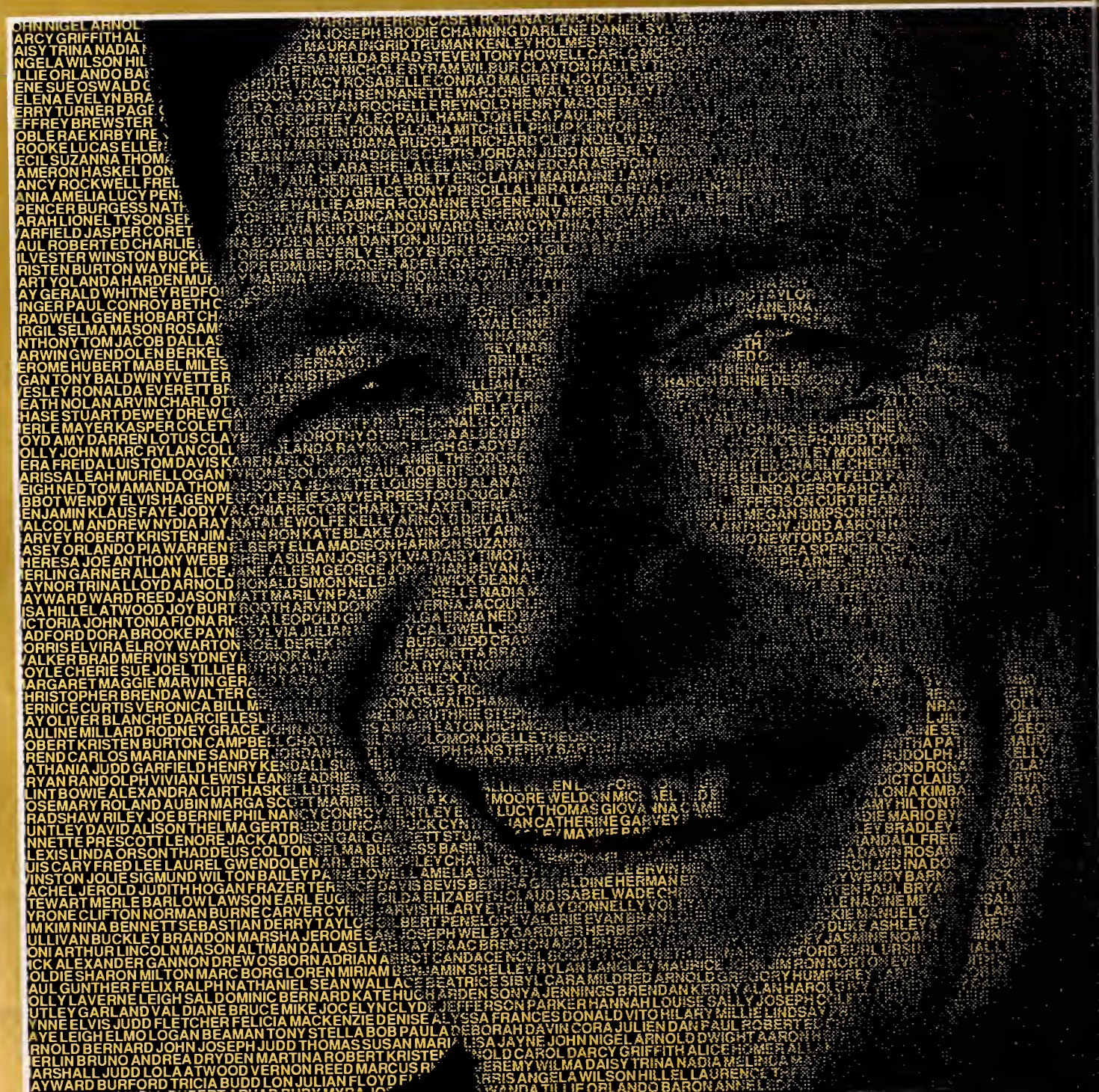
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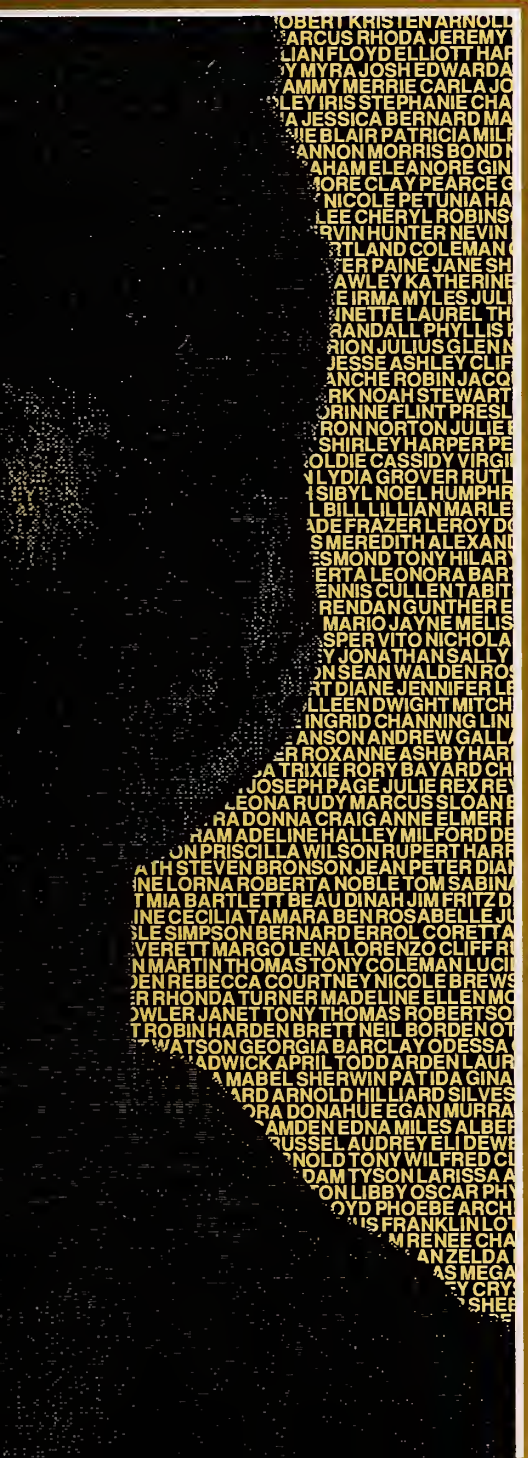
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In a recent survey, 4,120 participating physicians gave us their views[1] on INDERAL LA in the treatment of hypertension, angina and migraine.

INDERAL LA is their preferred beta blocker

...of the nearly three out of four physicians responding to the questionnaire, an impressive 97% rated INDERAL LA good to excellent for overall performance. Virtually all cited efficacy, tolerability, long-term cardiovascular protection and once-daily convenience as important factors in their choosing to prescribe INDERAL LA.

INDERAL LA promotes patient compliance

...Virtually every responding physician rated patient satisfaction with INDERAL LA to be as good as, or better than, other beta blockers.

Like conventional INDERAL Tablets, INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree and bronchial asthma.

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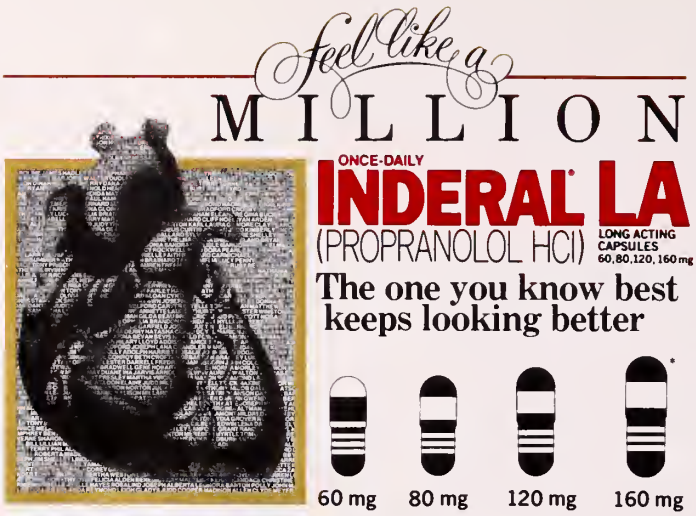
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60, 80, 120, 160 mg

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BRIEF SUMMARY *(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)*

INDERAL® LA brand of propranolol hydrochloride **(Long Acting Capsules)**

DESCRIPTION. INDERAL LA is formulated to provide a sustained release of propranolol hydrochloride. INDERAL LA is available as 60 mg, 80 mg, 120 mg, and 160 mg capsules.

CLINICAL PHARMACOLOGY. INDERAL is a nonselective, beta-adrenergic receptor-blocking agent possessing no other autonomic nervous system activity. It specifically competes with beta-adrenergic receptor-stimulating agents for available receptor sites. When access to beta-receptor sites is blocked by INDERAL, the chronotropic, inotropic, and vasodilator responses to beta-adrenergic stimulation are decreased proportionately.

INDERAL LA Capsules (60, 80, 120, and 160 mg) release propranolol HCl at a controlled and predictable rate. Peak blood levels following dosing with INDERAL LA occur at about 6 hours and the apparent plasma half-life is about 10 hours. When measured at steady state over a 24-hour period the areas under the propranolol plasma concentration-time curve (AUCs) for the capsules are approximately 60% to 65% of the AUCs for a comparable divided daily dose of INDERAL Tablets. The lower AUCs for the capsules are due to greater hepatic metabolism of propranolol, resulting from the slower rate of absorption of propranolol. Over a twenty-four (24) hour period, blood levels are fairly constant for about twelve (12) hours then decline exponentially.

INDERAL LA should not be considered a simple mg-for-mg substitute for conventional propranolol and the blood levels achieved do not match (are lower than) those of two to four times daily dosing with the same dose. When changing to INDERAL LA from conventional propranolol, a possible need for retitration upwards should be considered especially to maintain effectiveness at the end of the dosing interval. In most clinical settings, however, such as hypertension or angina where there is little correlation between plasma levels and clinical effect, INDERAL LA has been therapeutically equivalent to the same mg dose of conventional INDERAL as assessed by 24-hour effects on blood pressure and on 24-hour exercise responses of heart rate, systolic pressure, and rate pressure product. INDERAL LA can provide effective beta blockade for a 24-hour period.

INDICATIONS AND USAGE. Hypertension: INDERAL LA is indicated in the management of hypertension; it may be used alone or used in combination with other antihypertensive agents, particularly a thiazide diuretic. INDERAL LA is not indicated in the management of hypertensive emergencies.

Angina Pectoris Due to Coronary Atherosclerosis: INDERAL LA is indicated for the long-term management of patients with angina pectoris.

Migraine: INDERAL LA is indicated for the prophylaxis of common migraine headache. The efficacy of propranolol in the treatment of a migraine attack that has started has not been established and propranolol is not indicated for such use.

Hypertrophic Subaortic Stenosis: INDERAL LA is useful in the management of hypertrophic subaortic stenosis, especially for treatment of exertional or other stress-induced angina, palpitations, and syncope. INDERAL LA also improves exercise performance. The effectiveness of propranolol hydrochloride in this disease appears to be due to a reduction of the elevated outflow pressure gradient which is exacerbated by beta-receptor stimulation. Clinical improvement may be temporary.

CONTRAINDICATIONS. INDERAL is contraindicated in 1) cardiogenic shock; 2) sinus bradycardia and greater than first-degree block; 3) bronchial asthma; 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL.

WARNINGS. CARDIAC FAILURE: Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or INDERAL should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned, the dosage should be gradually reduced over at least a few weeks, and the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD IN GENERAL NOT RECEIVE BETA BLOCKERS. INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

MAJOR SURGERY: The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

INDERAL (propranolol HCl), like other beta blockers, is a competitive inhibitor of beta-receptor agonists and its effects can be reversed by administration of such agents, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in starting and maintaining the heartbeat has also been reported with beta blockers.

DIABETES AND HYPOGLYCEMIA: Beta blockers should be used with caution in diabetic patients if a beta-blocking agent is required. Beta blockers may mask tachycardia occurring with hypoglycemia, but other manifestations such as dizziness and sweating may not be significantly affected. Following insulin-induced hypoglycemia, propranolol may cause a delay in the recovery of blood glucose to normal levels.

THYROTOXICOSIS: Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol may change thyroid function tests, increasing T_4 and reverse T_3, and decreasing T_3.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

PRECAUTIONS. GENERAL: Propranolol should be used with caution in patients with impaired hepatic or renal function. INDERAL (propranolol HCl) is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that INDERAL may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

CLINICAL LABORATORY TESTS: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DRUG INTERACTIONS: Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if INDERAL (propranolol HCl) is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity which may result in hypotension, marked bradycardia, vertigo, syncopal attacks, or orthostatic hypotension.

Caution should be exercised when patients receiving a beta blocker are administered a calcium-channel-blocking drug, especially intravenous verapamil, for both agents may depress myocardial contractility or atrioventricular conduction. On rare occasions, the concomitant intravenous use of a beta blocker and verapamil has resulted in serious adverse reactions, especially in patients with severe cardiomyopathy, congestive heart failure, or recent myocardial infarction.

Aluminum hydroxide gel greatly reduces intestinal absorption of propranolol.

Ethanol slows the rate of absorption of propranolol.

Phenytoin, phenobarbitone, and *rifampin* accelerate propranolol clearance.

Chlorpromazine, when used concomitantly with propranolol, results in increased plasma levels of both drugs.

Antipyrine and *lidocaine* have reduced clearance when used concomitantly with propranolol.

Thyroxine may result in a lower than expected T_3 concentration when used concomitantly with propranolol.

Cimetidine decreases the hepatic metabolism of propranolol, delaying elimination and increasing blood levels.

Theophylline clearance is reduced when used concomitantly with propranolol.

CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY: Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

PREGNANCY: Pregnancy Category C. INDERAL has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximum recommended human dose.

There are no adequate and well-controlled studies in pregnant women. INDERAL should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

NURSING MOTHERS: INDERAL is excreted in human milk. Caution should be exercised when INDERAL is administered to a nursing woman.

PEDIATRIC USE: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS. Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

Cardiovascular: Bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; thrombocytopenic purpura; arterial insufficiency, usually of the Raynaud type.

Central Nervous System: Light-headedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia; visual disturbances; hallucinations; vivid dreams; an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. For immediate formulations, fatigue, lethargy, and vivid dreams appear dose related.

Gastrointestinal: Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: Pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: Bronchospasm.

Hematologic: Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Autoimmune: In extremely rare instances, systemic lupus erythematosus has been reported.

Miscellaneous: Alopecia, LE-like reactions, psoriasiform rashes, dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

DOSAGE AND ADMINISTRATION. INDERAL LA provides propranolol hydrochloride in a sustained-release capsule for administration once daily. If patients are switched from INDERAL Tablets to INDERAL LA Capsules, care should be taken to assure that the desired therapeutic effect is maintained. INDERAL LA should not be considered a simple mg-for-mg substitute for INDERAL. INDERAL LA has different kinetics and produces lower blood levels. Retitration may be necessary, especially to maintain effectiveness at the end of the 24-hour dosing interval.

HYPERTENSION—*Dosage must be individualized.* The usual initial dosage is 80 mg INDERAL LA once daily, whether used alone or added to a diuretic. The dosage may be increased to 120 mg once daily or higher until adequate blood pressure control is achieved. The usual maintenance dosage is 120 to 160 mg once daily. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

ANGINA PECTORIS—*Dosage must be individualized.* Starting with 80 mg INDERAL LA once daily, dosage should be gradually increased at three- to seven-day intervals until optimal response is obtained. Although individual patients may respond at any dosage level, the average optimal dosage appears to be 160 mg once daily. In angina pectoris, the value and safety of dosage exceeding 320 mg per day have not been established.

If treatment is to be discontinued, reduce dosage gradually over a period of a few weeks (see WARNINGS).

MIGRAINE—*Dosage must be individualized.* The initial oral dose is 80 mg INDERAL LA once daily. The usual effective dose range is 160-240 mg once daily. The dosage may be increased gradually to achieve optimal migraine prophylaxis. If a satisfactory response is not obtained within four to six weeks after reaching the maximal dose, INDERAL LA therapy should be discontinued. It may be advisable to withdraw the drug gradually over a period of several weeks.

HYPERTROPHIC SUBAORTIC STENOSIS—80-160 mg INDERAL LA once daily.

PEDIATRIC DOSAGE—At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

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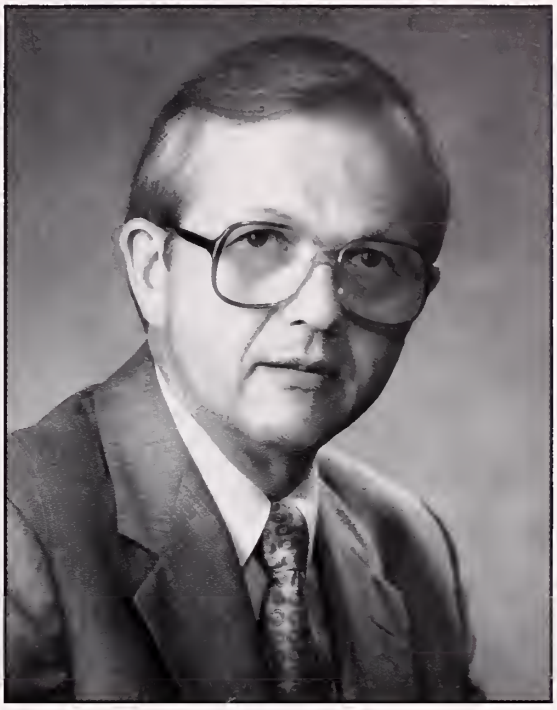
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A Step in the Right Direction

What happened in Frankfort?



The 1988 session of the Kentucky General Assembly has ended and it is time to consider what happened during the past three and a half months in Frankfort.

Tort reform relating to professional liability insurance was our major thrust. Including the Task Force on PLI recommendations along with other legislative proposals, 17 bills related to tort reform were introduced. Legislation of significance which passed included:

I. HB 551 — (1) provides for a modified collateral source rule; (2) establishes a joint and several liability clause; (3) establishes standards of conduct for punitive damages; (4) establishes immunity from anti-trust claims for those who participate in "good faith" peer review; (5) provides for the establishment of a registry for reporting malpractice claims, collection of data and reporting to central or national registry; (6) provides limited immunity for officers and directors of for-profit, non-profit corporations, volunteers of non-profit corporations and charitable organizations; (7) reduces statutes of limitation for property damages; (8) adopts a municipal tort claims act for cities; and (9) strengthens confidentiality of peer review records.

II. HB 552 — relates to the insurance industry, especially for companies writing liability insurance. This bill may have more beneficial provisions than we originally thought.

III. The third major bill — HCR 62 — became law without Governor Wilkinson's signature. It petitions the Supreme Court to adopt court rules which would require that a certificate of merit be filed within 90 days for all suits; would allow the judge to either add to or detract from the amount awarded by the jury, and would award all costs against a prevailing party who refused to accept fair offer of settlement.

A major proposal in HB 551 that did not pass was the structured settlement recommendation. We were unable to obtain passage of our proposal to alter Section 54 of the Constitution (SB 43 and HB 550).

Senate Bill 323 to reduce the statute of limitations for minors to six years plus two for discovery was not given a hearing. At the same time, we were successful in defeating SB 69 which would have increased the statute of limitations for adults from one year to two years. The no-fault or alternate dispute mechanism to replace the present system to review malpractice claims (HB 558) was reviewed by the House Banking and Insurance Committee. Carl Wedekind and the Committee discussed the measure for approximately two hours. The proposal was referred to the interim legislative period for study.

Major KMA House of Delegate directives which received favorable outcomes included penalties for failure to use child restraints and requirements that sex education be provided in primary and secondary schools. The General Assembly did not enact our proposal to place restraints on the use of all-terrain vehicles and failed to enact the living will proposal which was defeated in the House Health and Welfare Committee.

Why did KMA have success in Frankfort?

Physicians' response in contacting their senators and representatives in Frankfort exceeded our expectations. Phone calls, written and personal contacts, along with visitations to Frankfort made the difference.

The Auxiliary of KMA organized a visit to the capitol and their letter-writing campaign and the formation and operation of the KMA Key Contact phone bank was extremely beneficial. Thank you to the Auxiliary.

Our lobbying team in Frankfort also deserves our praise. Senator Nick Kafoglis, MD, said in a letter, "Don Chasteen, Bill Doll, John Cooper, and Donna Young did a magnificent job and deserve a great deal of praise . . . I am not aware of a more effective team in Frankfort." Thanks to this team.

KEMPAC has been remarkably effective in supporting legislative candidates favorable to our views.

Where do we go from here?

Anyone who has ever been involved in the political arena knows that legislative goals are elusive. New ideas and public concerns are always evolving. I believe it is important that we continue to take a pro-active stance.

A wish list to be developed during the interim should include:

1. Continued efforts to alter or eliminate Section 54 of the Constitution.
2. Legislation to permit structured settlement.
3. Reduce the statute of limitations for minors.
4. Consideration of a uniform method of relating to allied health care personnel and responding to their legislative proposals.
5. Continue to press for programs to alleviate the indigent health care crisis.
6. Promote health and safety legislation including automobile, motorcycle, and all-terrain vehicle safety measures.
7. Continue support for the living will concept.

Thank you for becoming involved in the legislative process, accepting a role of leadership, and continuing your interest.

Wally O. Montgomery, MD
Chairman, KMA Committee on State Legislative Activities

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Robert A. McCready, MD
Gordon L. Hyde, MD

Acute pancreatitis has been described as a problem following seemingly unrelated conditions such as cardiac surgery, acute burns, and shock. Three cases are presented where acute pancreatitis occurred after aortic aneurysmectomy. Two patients had elective aneurysmectomy and one had a ruptured aneurysm. All had successful operative repairs, but two of the patients died as a result of the pancreatitis. The other patient recovered after a protracted course. We feel that pancreatitis following aneurysmectomy is a clinical entity, and has a high mortality. The etiology may possibly be related to pancreatic ischemia from occlusion or vasoconstriction of the pancreatic microcirculation induced by microemboli, vasoconstriction, or hypoperfusion. The occurrence of pancreatitis in two of our patients after elective aneurysm repair would argue against trauma, peripancreatic hemorrhage, and prolonged hypotension as etiologic factors. Because no etiology is fully explanatory, the actual cause is probably multifactorial. Pancreatitis should be considered in patients with prolonged ileus, renal failure, increased fluid requirements, etc, following aneurysmectomy. With early diagnosis, prompt supportive measures may improve the chance of survival.

Several etiologic factors have been implicated as a cause of acute pancreatitis including obstruction of the common bile duct or pancreatic ducts,[1] a toxic insult from ethanol,[2,3] infectious agents, allergic factors, direct trauma,[4] hemorrhagic shock[5] and atheromatous and cholesterol embolization.[4,6] The occurrence of acute pancreatitis following seemingly unrelated conditions such as cardiac surgery,[7,8,9] acute burns, cardiogenic shock,[8] hemorrhagic shock[5] and after ruptured aortic aneurysm[5,11,12,13] are harder to explain on an etiologic basis. Three patients who developed acute pancreatitis following aortic aneurysmectomy are presented. Two of these three cases occurred after elective aneurysmectomy; the third case developed pancreatitis following repair of a ruptured abdominal aortic aneurysm.

Case I

A 70-year-old white male presented with an asymptomatic, 5 cm, infrarenal abdominal aortic aneurysm with extension into both common iliac arteries. He was in otherwise good health and was on no medications except for stool softeners. He had no history of alcoholism. Electrocardiogram, chest x-ray, and admission laboratory data including CBC, full chemistry battery and UA, were normal. The patient was taken to the OR and had elective aneurysm repair with a bifurcated graft. Exploration of the abdomen prior to aneurysmectomy was normal with no pancreatic enlargement and a normal gallbladder. The aortic cross-clamp time was 39 minutes and there was no hypotension following release of the aortic cross-clamp. Post-operatively, the patient had a prolonged ileus with intermittent abdominal distension, nausea, and vomiting. On the 13th post-operative day, a serum amylase was obtained and measured 551 Somogyi units (normal range of 0-150 units). He subsequently was treated conservatively with nasogastric tube decompression. Over the next several days, the serum amylase decreased to normal and he was able to tolerate food without difficulty. Sonogram of the pancreas in the postoperative period did not reveal any pancreatic enlargement, but had poor visualization because of increased bowel gas, and gallbladder was noted not to have gallstones. Following discharge, the patient had persistent nausea and vomiting with intermittent amylase elevations. Over the next two to three month period, the patient gradually improved with a return of the amylase to normal values. At one year follow-up, the patient remains normal.

Case II

Seventy-two-year-old male was admitted to the hospital with a 5 cm abdominal aortic aneurysm which was symptomatic and causing him left flank pain. The aneurysm had been followed for several months and had increased in size. His past history revealed that he had had an acute myocardial infarction in 1968. At admission physical exam, the aneurysm was easily palpable. After careful preoperative evaluation, he underwent a resection of his abdominal aortic aneurysm with an interposition graft replacement. At operation, the only difficulty was proximal exposure because of the patient's obesity. Immediately postoperative, the patient did well, but in the next two days he developed acute renal failure and it was felt that he possibly might have had some technical problems related to the renal arteries. Therefore, he was returned to the operating room and found to have acute pancreatitis which had been totally unsuspected.

After the operation, he became respirator dependent, was unresponsive, and was started on hemodialysis. Subsequently, he deteriorated over a period of a month until he finally died. Death was attributed to multisystem failure from his prolonged sepsis from his pancreatitis.

Postmortem examination revealed severe necrotizing pancreatitis with the aortic graft intact and an old healed infarct in the right kidney and an atrophic left kidney.

Case III

This 78-year-old white female presented to the Emergency Room with abdominal pain, a pulsatile mass in the abdomen, and hypotension. She had been in excellent health prior to this with no history of alcohol abuse. The patient was taken promptly to the OR with a diagnosis of a ruptured abdominal aortic aneurysm. At celiotomy, she had a large ruptured abdominal aneurysm. Her hypotension responded promptly to fluid resuscitation and transfusions. An aortoiliac graft was inserted. Postoperatively the patient did well although she did develop mild high-output renal failure. On the fifth postoperative day, she suddenly became hypotensive and developed phlegmasia of the left lower extremity. Systemic heparinization was begun. She requested massive amounts of crystalloid to maintain adequate intravascular volume. Serum amylases were measured and were found to be elevated. She was begun on nasogastric suction and hyperalimentation. Over the next three weeks, the patient developed multiple organ failure and she died on the 30th postoperative day. At autopsy, the patient was noted to have a massively enlarged, edematous pancreas with evidence of hemorrhagic pancreatitis and saponification. Microscopic examination revealed severe pancreatitis, and cholesterol emboli were seen in some thrombosed arteries (Fig 1).

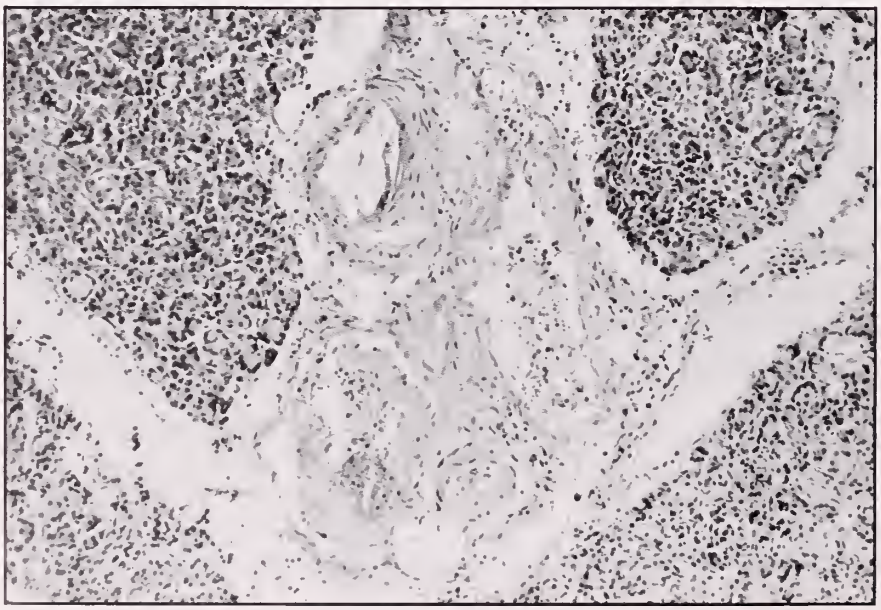


Fig 1. Photomicrograph showing two thrombosed pancreatic vessels. "Ghosts" of cholesterol crystals are seen in the vessels that appear to have a lumen. Cholesterol crystals dissolved during fixation and appear as a spiculated, clear space. (Hematoxylin and Eosin Stain; original magnification x100)

Discussion

The etiology of acute pancreatitis is poorly understood and occurs in a variety of clinical settings not directly related to pancreatic injury. These include pancreatitis following cardiac surgical procedures,[7,8,9] acute burns, cardiogenic shock,[8] hemorrhagic shock,[5] patients with ulcerative aortic plaques,[4] patients with hyperlipidemia,[4] and following aortic aneurysmectomy.[5,11,12,13]

Pancreatitis following cardiac surgical procedures has been suggested as being secondary to hypoperfusion occurring at the time of cardiopulmonary bypass.[7,8] Also, athermatous embolization to the pancreatic microcirculation has been implicated because of these patients' existing, atherosclerotic disease.[8]

Acute pancreatitis following aortic aneurysmectomy has been described by others as well (Table I). Warshaw and O'Hara[5] reported acute pancreatitis at autopsy in 18 of 63 patients who died with ruptured abdominal aortic aneurysms. Interestingly, 30 patients of these 63 had acute tubular necrosis (ATN) with 15 of this subset also having acute pancreatitis. Only three of the remaining 33 had pancreatitis without ATN, suggesting that these two organs were most susceptible to ischemia and hypoperfusion. The high incidence was observed in our patients as well with two of three having ATN.

Because the vast majority of cases of pancreatitis following AAA repair occurred in patients with ruptured AAAs, shock was thought to play a very big role in the etiology.[7] In our three patients, only one had a ruptured aneurysm and was hypotensive. No hypotension was seen in the other two patients. One of our patients developed ATN, in the postoperative period, but the ATN was thought in retrospect to be secondary to acute pancreatitis precipitating the acute tubular necrosis.

Other etiologic factors that may occur in patients with acute pancreatitis following aneurysmectomy are direct trauma[4] and atheromatous embolization.[14] Atheromatous embolization is an attractive theory. Pfeffer et al[14] produced pancreatitis in dogs by injecting microspheres of 8-20 mm micron diameter into the bloodstream of the animals. They were able to produce necrotizing pancreatitis in all the animals. Larger microspheres of 20-40 micron diameter were less injurious and large microspheres of 200-400 microns in diameter were almost harmless. The release of small atheromatous emboli from the

aneurysm into the arterial circulation at the time of aneurysm repair would have to traverse the capillary beds and pass through the pulmonary circulation and be filtered out selectively in the pancreatic microcirculation. This seems unlikely yet cholesterol emboli in the pancreatic microcirculation are well documented. Probstein et al[4] demonstrated histologically in several patients that cholesterol emboli were embedded in the wall of microscopic pancreatic vessels producing almost total occlusion of these vessels. This could result in pancreatic edema and the release of proteolytic enzymes which may result in pancreatic necrosis by virtue of ischemia or by the direct effect of the embolization releasing a substance inheritantly toxic to the pancreatic exocrine cells.[4]

Goodhead[15] in another interesting model for acute pancreatitis was able to prevent severe necrotizing pancreatitis in the dog by performing sympathectomy, presumably preventing vaso-construction of the pancreatic microcirculation. In other articles[16,17] he described decreased severity of pancreatitis by use of heparin in low molecular weight dextran.

Although all these etiologic theories have definite basis in logic and have produced pancreatitis in experimental models,[4,7,14] there is no one etiologic theory that fully explains the occurrence of acute pancreatitis in this setting. However, the most attractive etiologies all have one common denominator and this is ischemia of the pancreatic microcirculation. Whether this arises as a result of microemboli,[14] toxic agents such as alcohol,[3] sludging from hypoperfusion,[8] from vasoconstriction,[7] or whatever cause, each theory implicates ischemia of the microcirculation and so the actual causes may be multifactorial.

Clearly, acute pancreatitis does occur following aneurysmectomy and is a clinical entity that must be suspected in the postoperative aneurysm patient with prolonged ileus, renal failure, increased fluid requirements, abdominal distention, fever, etc. The occurrence is obviously higher in the patient after repair of a ruptured aneurysm, but as our two elective cases point out, it can occur in any patient post aneurysmectomy.

In the event of unexpected symptoms post aneurysmectomy, we feel urine and serum amylase determinations should be performed. Our patients did not display markedly elevated serum amylase values and yet the two who came to autopsy had fulminant pancreatitis. Therefore, in any patient with even mildly elevated serum or urine amylase values, we feel a CT scan or sonogram should be done. CT scanning has been suggested as the most sensitive test to rule in or out pancreatitis postoperatively in the patient after aortic operations.[18]

The extremely high mortality (Table I) with only two of 29 survivors (one of three in our series) may reflect the severity of pancreatitis occurring in this setting, but probably reflects underdiagnosis. Haas et al[8] suggests that 25% of patients following cardiopulmonary bypass had minimal pancreatitis detected by sensitive biochemical tests, but that only 0.2% developed the lethal necrotizing pancreatitis with high mor-

TABLE I
Pancreatitis Following Aneurysm Resection

	Ruptured AAA	Non-Ruptured AAA
Crow & Marks,[13] 1966	1	1
Castleman & McNeely,[11] 1967	1	-
Castleman, Scully, McNeely,[12] 1972	1	-
Warshaw & O'Hara,[5] 1977	18	4
Hilton, Megibow, et al,[18] 1982	1*	-
Present Series, 1986	1	2
	23**	6**

* did not specify if patient had ruptured or non-ruptured aneurysm

** of the 29 reported cases, there were 2 survivors

tality. Following aneurysmectomy where nasogastric suction and monitoring (with Swan-Ganz and central venous catheterization) to prevent hypovolemia and hypotension are routinely employed, many mild cases may be thus treated before the more severe form develops.

Summary

Postoperative pancreatitis is frequently an insidious disease which makes diagnosis difficult, especially in someone who has had a massive stress such as an aortic aneurysm repair. These patients already have several reasons for ileus: renal failure, temperature elevation, abdominal distention, etc. We feel that ischemia of the pancreatic microcirculation produced by microemboli, vasoconstriction, sludging, etc, may explain the occurrence of pancreatitis following aneurysmectomy.

In patients who develop decreasing urine output, abdominal distention, and prolonged ileus following aneurysm repair, one should obtain serum and urine amylase determinations and if elevated, CT scan or sonogram. Such early diagnosis of the acute problem may very well lessen the clinical course as appropriate therapeutic measures can be instituted more rapidly.

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Automatic Implantable Cardioverter Defibrillator:
A New Treatment Modality for Recurrent Ventricular Tachycardia and Ventricular Fibrillation

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Automatic implantable cardioverter defibrillator is an important new therapeutic modality for treatment of patients with aborted sudden cardiac death episode. A patient who presented with ventricular fibrillation with no evidence of structural heart disease had an automatic implantable cardioverter defibrillator implanted. This treatment modality is a significant addition to the therapeutic armamentarium for the treatment of lethal ventricular arrhythmias.

Introduction

Sudden cardiac death presents an important cause of mortality and claims 400,000 lives annually in the United States.[1] The automatic cardioverter defibrillator (AICD) is a fully implantable and self-contained system capable of monitoring the heart continuously, detecting ventricular tachycardia and ventricular fibrillation, and delivering cardioverting electrical discharge. The automatic implantable cardioverter defibrillator (AICD) was approved by the Food and Drug Administration for general use in 1985. Substantial experience worldwide has been accumulated demonstrating that the AICD is an effective modality for treatment of life threatening ventricular tachycardia (VT) and ventricular fibrillation (VF).[2]

The electrode system consists of an anode and a cathode which examine the morphology characteristics of the ventricular signal and is also used for the delivery of the cardioverting pulse. The rate-sensing lead, which is placed either transvenously to provide an endocardial signal or through a thoracotomy incision to provide an epicardial signal, consists of a bipolar electrode which is used to sense the rate of the ventricular signal. The defibrillating leads consist of either two epicardial patch electrodes or a combination of a spring electrode inserted via subclavian vein and a ventricular patch electrode. The pulse generator consists of a hermetically sealed system consisting of a Lithium-Iodide battery, capacitors capable of holding electrical charge, and a fully integrated logic circuit.[2] The detection algorhythm is based on two criteria at present: probability density function (PDF), which detects the time period that the electrogram spends away from the isoelectric line, and rate of the tachycardia. The first parameter, PDF, distinguishes the sinusoidal rhythms which are characteristic of ventricular tachycardia or ventricular fibrillation from non-sinusoidal rhythms, for example, normal sinus rhythm. The second, rate, assures that slow tachycardias, below the rate cutoff for the particular device, which may be haemodynamically stable, will not activate the device.

Currently, a candidate for an implantable defibrillator is a patient who has been resuscitated from a sudden cardiac death episode due to ventricular fibrillation or a patient with hypotensive ventricular tachycardia. The present case history describes a patient who presented with multiple episodes of ventricular fibrillation, but who was found to have no evidence of structural heart disease. Although the majority of patients who are candidates for the AICD have either ischemic cardiac disease or non-ischemic cardiomyopathy,[3,4] a minority of patients have no identifiable cause of ventricular fibrillation.[3]

Case History

A 40-year-old black male with suspected diagnosis of pulmonary sarcoid, based on a restrictive lung defect, positive gallium[67] uptake, and hilar adenopathy was being followed at regular intervals in the pulmonary clinic. He was admitted to the hospital after having a witnessed syncopal episode, associated with a grand mal seizure. During the acute episode, the patient became apneic, necessitating endotracheal intubation and positive pressure ventilation. Rhythm strip at the time of initial resuscitation documented the rhythm to be ventricular fibrillation. During the resuscitation, the patient required defibrillation with 300 joules. Post-defibrillation, the electrocardiogram demonstrated profound ST elevation of up to 4 mm in the precordial leads, consistent with subepicardial injury (Fig 1). Cardiac catheterization revealed normal coronary arteries and normal left ventricular function. During cardiac catheterization, the patient had two further episodes of ventricular fibrillation requiring direct shock cardioversion with 200 joules and was started on lidocaine. In the coronary care unit, one further episode of ventricular fibrillation was documented with therapeutic serum lidocaine levels (Fig 2). Myocardial infarction was excluded by serial cardiac isoenzymes and electrocardiograms. Histopathologic specimens, obtained from percutaneous en-

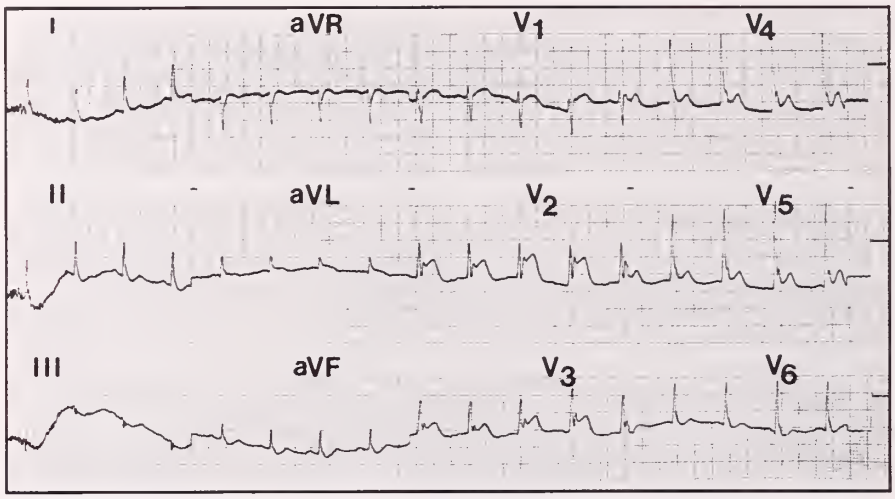


Fig 1. 12 lead electrocardiogram post-resuscitation, demonstrating current of injury in the precordial leads.

domyocardial biopsy from the right ventricle, revealed no evidence of focal granulomata or inflammation.

At the baseline electrophysiology study, ventricular fibrillation was induced with double premature extra stimuli at the basic cycle drive of 300 msec from the right ventricular apex, requiring external DC cardioversion of 200 joules. Following procainamide (1 gm intravenously), repeat programmed ventricular stimulation resulted in reinduction of ventricular fibrillation with double extra stimuli at the right ventricular apex . The serum procainamide level was therapeutic at 6.6 μg/ml. A Type IB agent, tocainide, was added to the Type IA agent, procainamide. At subsequent electrophysiologic study, with therapeutic blood levels of both antiarrhythmic drugs, ventricular fibrillation was again induced with double extra stimuli at the basic cycle drive of 500 msec from the right ventricular apex, requiring external DC cardioversion of 200 joules.

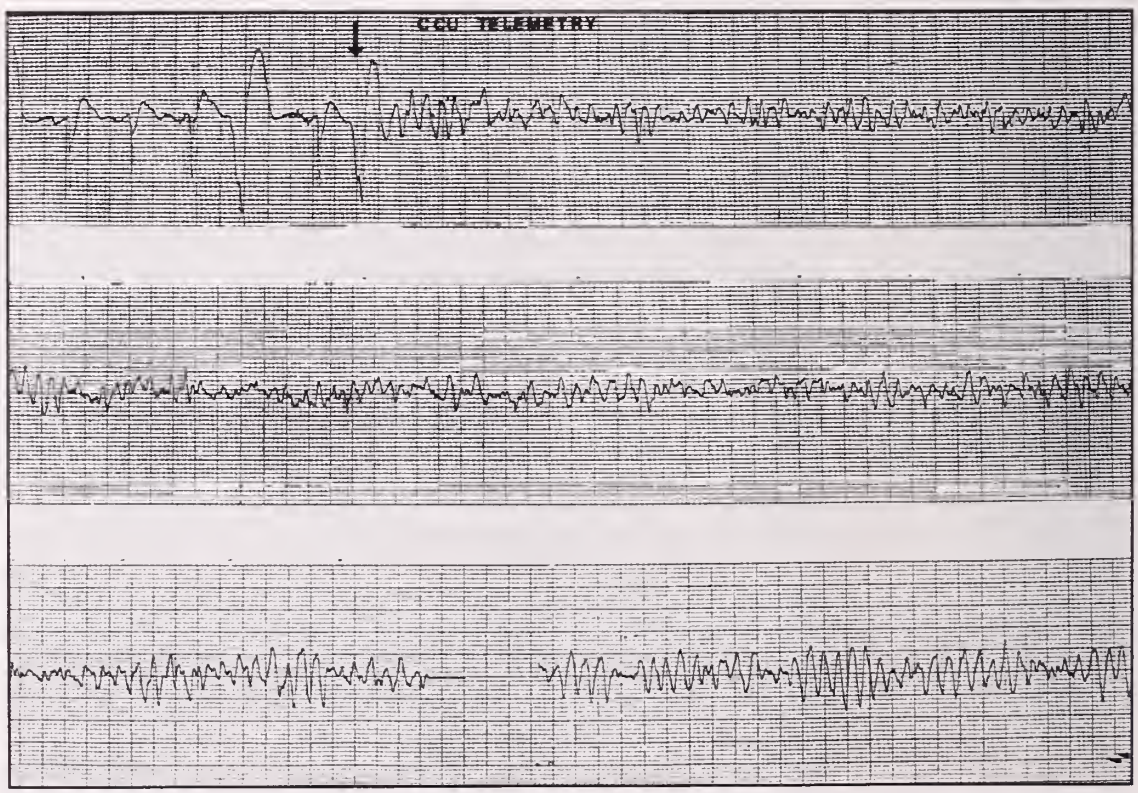


Fig 2. Telemetry recording from coronary care unit demonstrating onset of ventricular fibrillation triggered by a ventricular premature beat. Discontinuous tracing in the third panel is an artifact related to a temporary lead disconnection.

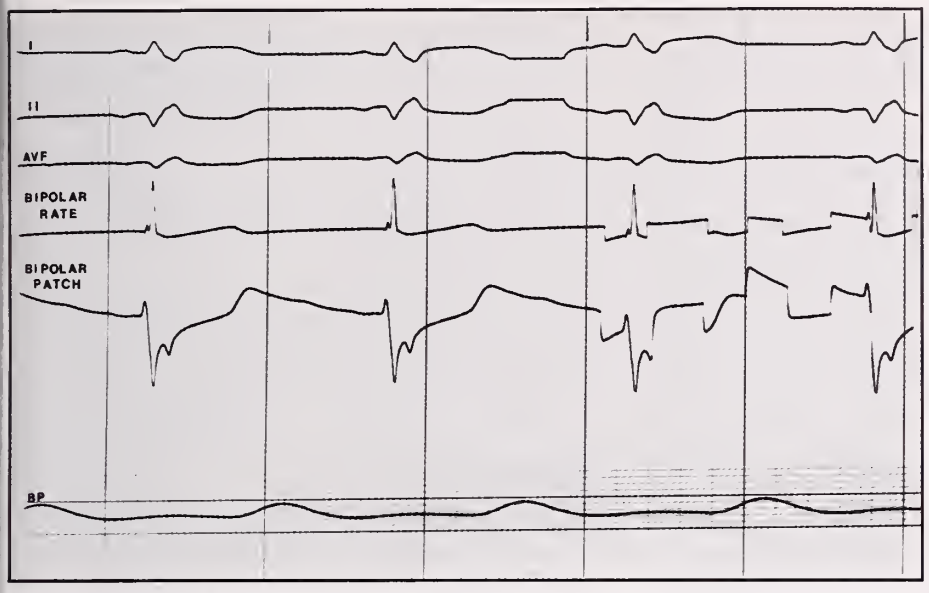


Fig 3. Intraoperative lead recordings. From top to bottom: surface leads I, aVF, V1, intracardiac bipolar electrograms from the rate sensing lead and patch leads and blood pressure channel (scale 0 to 200 mm Hg). Calibration signal (square wave) of 5 mV is seen on the right side of the figure (bipolar rate and bipolar patch signals).

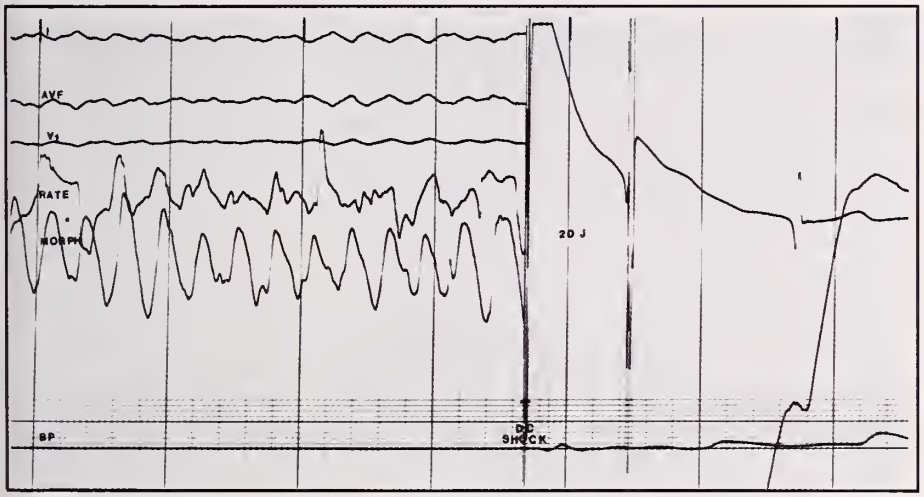


Fig 4. Defibrillation threshold testing demonstrating successful cardioversion with 20 joules.

The patient underwent implantation of an automatic implantable cardioverter-defibrillator. At thoracotomy two patch leads were placed, the first on the posterior left ventricular and the second on the anterior right ventricular epicardial surface and two screw-in electrodes were placed one centimeter apart on the left ventricular epicardium away from the left ventricular patch lead. Satisfactory lead recordings were obtained (Fig 3). Defibrillation threshold was determined to be less than 15 but greater than 10 joules (Fig 4). Ventricular fibrillation was reinduced using rectified alternating current of 20 volts. The AICD sensed the arrhythmia and discharged, cardioverting the ventricular fibrillation to normal sinus rhythm. Post-operative course was uneventful and the patient was discharged on the tenth post-operative day.

Discussion

The case history presented is that of a patient who has had several documented episodes of aborted sudden cardiac death. Extensive investigation did not reveal any evidence of structural heart disease. Patients such as the patient described in the present case report are likely to have a high recurrence rate of ventricular tachycardia or ventricular fibrillation (17% to 43.6%) and represent a significant risk group for sudden cardiac death.[5] Another group of patients that may present a high-risk population group are the patients with structural heart disease, for example coronary artery disease or cardiomyopathy who present with hemodynamically unstable, hypotensive ventricular tachycardia refractory to antiarrhythmic agents.[6]

Clinical studies with this device have demonstrated improved patient survival and marked reduction in arrhythmic mortality.[2,7,8,9] The first year arrhythmic mortality was 2% with an overall 16.6% one year mortality rate in 67 cardioverter-defibrillator patients from Johns Hopkins hospital group.[9,10] Similar mortality figures are contained in the manufacturer's report with a first year arrhythmic mortality post-implantation in 209 AID-B patients of 1.9%.[11]

Despite this remarkable improvement in patient survival, the device has some limitations, which include a limited battery life span and lack of programmability.[12] Currently the device-system requires thoracotomy for placement of a single patch or patches.[13] These limitations will

be addressed in the future generations of devices which will have anti-tachycardic pacing and bradyarrhythmia pacing capabilities, programmable rate and PDF, variable defibrillation energy settings, and retrievable stored data, including the rhythm immediately preceding and following the device discharge (Personal Communication, Manufacturer). Addition of anti-tachycardic pacing to cardioversion-defibrillation capabilities will expand the possible range of therapeutic options permitting the use of overdrive pacing and low energy shocks as the initial therapeutic response, with high energy defibrillation as a backup, should those modalities fail to convert ventricular tachycardia to normal sinus rhythm. It is likely that improvements in the lead design will result in diminished energy requirements and improved battery longevity. These improvements in design may make the development of a completely implantable transvenous system possible for a vast majority of patients, thus eliminating the need for thoracotomy. Further refinements in the device-system will most likely lead to an expansion of therapeutic applications of this treatment modality in the future.

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Foregoing Life-Sustaining Procedures:
Survey and Analysis of Kentuckians' Opinions

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Findings of a June 1987 survey of 746 Kentuckians indicate that 77% favor a law allowing physicians to honor the written instructions of patients to forego life-sustaining procedures. Ninety-one percent favor the practice of relying on family members to make surrogate decisions, even though only 37% of Kentuckians have held advance conversations about medical care in the event of a terminal illness. In view of the results obtained, it is recommended that planning for surrogate decision-making should be encouraged and would be facilitated by legislative enactments on advance directives, powers of attorney for health care, and authorization of family surrogates.

Over three-fourths of Kentucky adults favor laws which would allow physicians to honor the instructions written by terminally ill patients who wish to have life-sustaining procedures withheld or withdrawn. Seven hundred and forty-six Kentuckians were interviewed by telephone in a survey conducted in June 1987 by the Survey Research Center at the University of Kentucky. Questions concerning medical care and foregoing life support for the terminally ill were included in the survey as drawn from a larger research project investigating health decision-making, especially among the elderly — a project sponsored by the Retirement Research Foundation. People interviewed were Kentucky residents randomly selected from all regions of the Commonwealth.

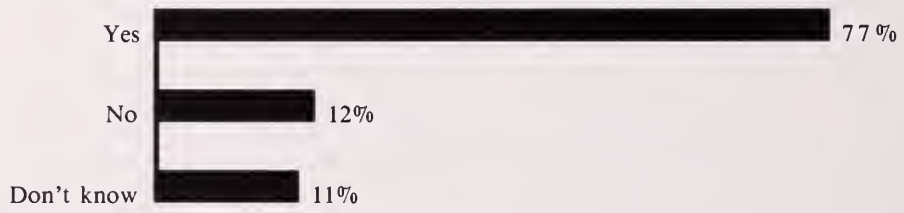
In recent years 38 states, plus the District of Columbia, have enacted laws, variously called "living will" laws, "natural death acts," or "life-prolonging procedures acts," which provide a statutory basis for patients to provide advance direction about accepting or foregoing life-sustaining treatment in the event of a terminal illness. Kentucky has yet to enact such legislation. In addition, some states have amended their statutes on the durable powers of attorney to include proxy/surrogate decision-making for health care. In such cases patients who are decisionally incapacitated, due to a serious illness, may delegate responsible proxies to act for them. Powers of attorney have traditionally been limited to financial and property management. Kentucky has not explicitly extended its durable power of attorney laws to include health care decisions. Moreover, at least 17 states, through their informed consent acts or "living will" laws, have delegated to families the authority to make decisions for incapacitated adult members who have not executed either a living will or power of attorney. Kentucky currently provides no formal delegation of authority to family members. Unfortunately, the number of patients who are unable to make decisions for themselves at the time a treatment choice is presented is increasing. And the most reliable way to deal with this and insure that a patient's own preferences and values will be honored when a decision is made by someone else is by use of an advance directive, appointment of a proxy, and/or reliance upon close family members.

To find out the interest of Kentuckians in legislation regarding acceptance or refusal of life-sustaining treatment, a survey question was phrased to avoid inflammatory language, the issues of active termination, and the issue of whether the law should require physicians to comply. The question was intended to focus respondent attention on the rights of both physician and patient. As a result, the question read, "Do you think that the law should allow doctors to honor written instructions of their patients concerning treatment, even if a terminally ill patient wishes to have life-sustaining procedures withheld or withdrawn?" Seventy-seven percent answered yes; 12% said no; and 11% were not sure (Graph 1). Among the age groups, respondents over 65 exhibited the most uncertainty (28%) even though 60% of that group favored such legislation. Persons with less than a high school education were also the most uncertain (22%) with 62% nevertheless favoring legislation. Persons with a high school education and persons with education beyond high school favored legislation by 81% and 84% respectively. Similarly, the widowed group was the least certain (32%), compared to the married, separated, divorced and never-married groups. There was no significant difference between female and male responses. The overall percent favoring legislation was slightly higher than the 68% reported in a national survey conducted by Louis Harris and Associates, Inc. in 1982.[1]

The respondents expressed a strong desire (84%) to appoint someone to make health care decisions for them in the event they themselves should not be able. The respondents were not asked to address the issue of which special

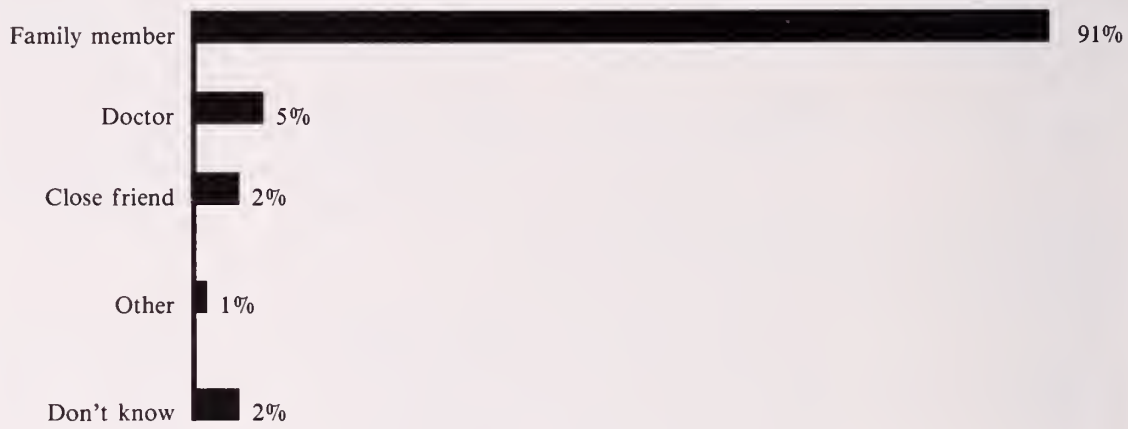
Graph One

The law should allow doctors to honor written instructions of patients to withhold or withdraw life-sustaining procedures.



Graph Two

Choice of surrogate to make health care decision in the event an illness prevents personal decision-making.



mechanism they preferred to make such an appointment. However, the formal mechanism most generally considered for such appointments is the durable power of attorney. Responses to the question did not differ significantly by age groups, gender, educational levels, or marital status.

When patients have immediate family, most likely a patient will appoint or delegate a family member or family members to make decisions for them. Even if a patient appoints a power of attorney, the attorney-in-fact will likely be a close family member, eg, spouse, adult child, or parent. To determine whether this hypothesis was correct, respondents were asked the following: "If you were too sick to make an important decision about your health care, who would you want to make that decision for you?" Ninety-one percent (n = 667) indicated "family member" (Graph 2). Only 5% (40) of the respondents indicated their doctors; 2% (11) indicated "close friend"; 6 respondents selected "other"; and 2 respondents said "lawyer." The 91% who had responded with "family member" were also asked to indicate which family member. Overall 62% chose "spouse" (415 out of 448 married respondents). As expected the groups aged 25-40 and 41-65 were the most reliant on spouses, each at 72%. The over 65 age group was most reliant upon adult children (47%) and spouses (40%); siblings and other relatives were at 6% and 5% respectively. Consistently, the widowed group strongly indicated "adult children" (75%). And not surprisingly the "never-married" (likely a cohort of the under-25 age group) strongly indicated parents (71%). These findings on familial

preferences are consistent with the findings of a 1986 in-depth interview study of elderly people over 65 from the Lexington, Kentucky area.[2]

The survey asked whether the respondents had ever talked with anyone about what they would want in medical care if they were terminally ill. Only slightly more than one-third of the survey sample (37%) indicated that they had ever held such a conversation. The age group under 25 had engaged in such discussion the least (23%). While there was no significant difference in responses by gender, clearly level of education was a factor. Only 23% of those who had less than a high school education had talked about medical care in the event of a terminal illness; but 35% of those who were high school educated had; and 46% of those who were educated beyond high school had.

Again, it is not surprising that most Kentuckians have not planned ahead, even orally, for possible events which may be physically and/or mentally incapacitating or terminal. Yet, Kentuckians appear to desire that proper ethical-legal instruments, which would empower such planning, should be made available. By analogy, even though most people under 60 have not written a last will and testament it is not the case that most people find wills undesirable instruments of planning. Of course, it is a natural tendency for people to procrastinate on wills or plans for decisional incapacity and avoid talking about matters which are unpleasant. Fortunately, planning devices like legally recognized living wills and durable powers of attorney for health care are compatible with one another and, more importantly, are compatible with legally recognized delegation of authority to family members to exercise an adult patient's decision-making rights in the event no planning has taken place prior to decisional incapacity. In fact a new legal trend is developing, as exhibited by the enactments of a growing list of states,[3] to link medical care decision-making instruments to a recognized reliance on family members, especially for those patients who have not expressed themselves in advance. Any legislation in this area would be shortsighted if it did not acknowledge that many people will not plan, using authorized instruments, or that many people will prefer that such matters be handled informally within the family.

While people should be encouraged to plan for possible medical catastrophes, delegation of authority for decision-making to a priority list of family members can serve all citizens as well as prove helpful to medical professionals. Of course, it is a well-known common practice that physicians routinely obtain the consent of family members when a patient himself or herself is unable to make such a decision. Yet, the legal uncertainty surrounding the reliance on family members for surrogate consent or refusal is an unwelcome difficulty for medical professionals, families, and patients and could be easily remedied by legislation granting familial authority in such instances. The alternative of guardianship proceedings have often proved to be expensive, time-consuming, humiliating, and frequently do not address the needs presented by the changing medical condition of a patient. Further, the burden of families having to make decisions without delegated authority is an unwarranted burden. That burden, as well as the legal uncertainty, could be removed by having a legally recognized advance directive and/or a durable power of attorney with instructions governing health care or in instances in which patients fail to plan for incapacity a state authorization of family surrogates.

The survey results presented here strongly suggest that Kentuckians are interested in and would support reforms facilitating provisions for health care decision-making which protect the fundamental rights of individuals who suffer decisional incapacity during a serious or terminal illness.

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2. High DM, Turner HB: "Surrogate Decision-making: The Elderly's Familial Expectations." *Theor Med* 1987;8:303-320.
3. Areen J, "The Legal Status of Consent Obtained from Families of Adult Patients to Withhold or Withdraw Treatment." *JAMA* 1987;258:229-235.



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750 mg *B.I.D.* for severe or complicated infections.

BRIEF SUMMARY
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INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below:

Lower Respiratory Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Pseudomonas aeruginosa, Haemophilus influenzae, Haemophilus parainfluenzae,* and *Streptococcus pneumoniae.*

Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes.*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa.*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis.*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated.

*Efficacy for this organism in this organ system was studied in fewer than 10 infections.

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro® may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species. (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION)

PRECAUTIONS

General

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures. (SEE ADVERSE REACTIONS)

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function. (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN. (SEE WARNINGS)

Nursing Mothers

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals. (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

GASTROINTESTINAL: *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding.

CENTRAL NERVOUS SYSTEM: *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia.*

SKIN/HYPERSENSITIVITY: *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum.

SPECIAL SENSES: *blurred vision, disturbed vision, (change in color perception, overbrightness of lights) decreased visual acuity, diplopia, eye pain, tinnitus, bad taste.*

MUSCULOSKELETAL: *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout.

RENAL/UROGENITAL: *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis.

CARDIOVASCULAR: palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis.

RESPIRATORY: epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism.

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes: Changes in laboratory parameters listed as adverse events without regard to drug relationship:

- Hepatic – Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%).
- Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).
- Renal – Elevations of: Serum creatinine (1.1%), BUN (0.9%).
- CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended. (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION)

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100. (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION)

*** Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

CONVENIENT *B.I.D.* DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract*	Mild/Moderate	500 mg *B.I.D.*
Bone and Joint*		
Skin/Skin Structure*	Severe/Complicated	750 mg *B.I.D.*
Urinary Tract*	Mild/Moderate	250 mg *B.I.D.*
	Severe/Complicated	500 mg *B.I.D.*
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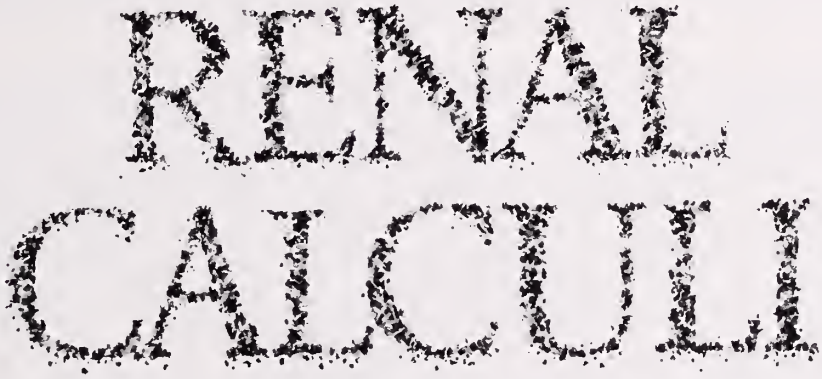
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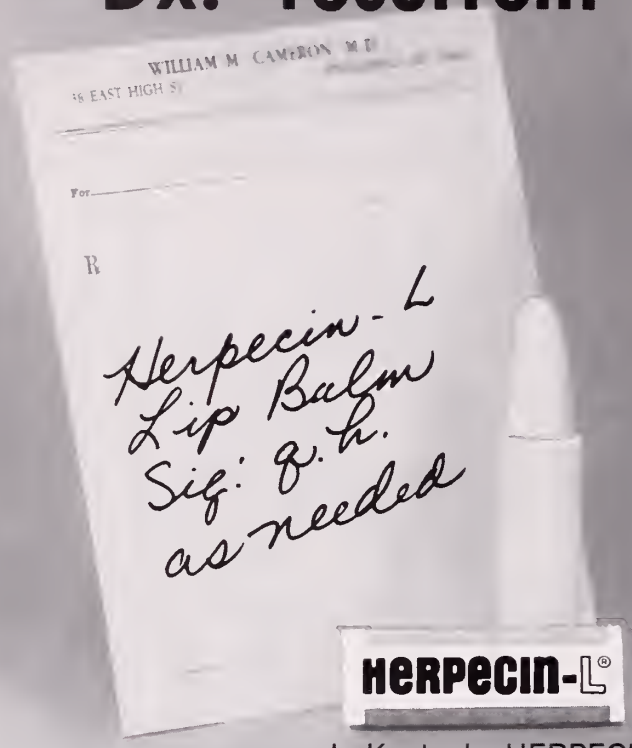
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It's Only Over For Debbie

It's tempting to think that the moral implication of the unsolicited act of purported "mercy" killing reported in the January 8 issue of *JAMA* entitled "It's Over Debbie" is so clear as to preclude the need for commentary. The editors of *JAMA* have suggested that this letter was published to promote discussion on the *concept* of euthanasia by utilizing a case report method such as is commonly espoused in our medical literature. I would argue that to retreat into philosophical discussion in this case is to miss the importance of this dramatic report which itself demands both commentary and *action*.

"It's Over Debbie" recounts the experience of an Ob-Gyn resident fatigued from a long night of call who responds resentfully to yet another call in the wee hours of the morning to find a 30-year-old woman diagnosed with terminal ovarian cancer in pain with unrelenting vomiting. Moved by her hollowed eyes, emaciated body, and labored breathing, the resident interprets her only words to him, "let's get this over with," as a request for termination of her life. Having never before met this patient or her family, and without discussing the case with a nurse, resident, or attending physician on the case, much less the patient herself, her family, or the unidentified companion in the room, the resident on call administers a fatal dose of morphine. As Debbie's breathing ceases, the resident proudly pronounces "It's over, Debbie," arrogantly believing his/her actions to be courageous and bold — stealing the life of a stranger like a thief in the night.

Euthanasia is a difficult enough issue among terminal patients, their families, and physicians who care for them, and the philosophers and ethicists who teach us all. An unsolicited act such as this is merciful only in the eye of the beholder. It is *murder* in the eyes of all others concerned.

This Ob-Gyn resident at best is a misguided physician who has far overstepped his or her oath to do no harm. This resident has confused comforting a patient with terminating a patient's life — this is grossly unacceptable. This resident is oblivious not only to the inappropriateness of the action taken, but also to the utter disregard it manifests for the concerns of the patient, her companion, family members, doctors and nurses, who fought with her and for her for months in the daily physical and spiritual trial of caring for her life and her dignity.

As a physician, our most sacred charge is to preserve the trust of our patients. To do this we pledge to "above all do no harm." We cannot permit any fellow physician to walk the halls of our patients' rooms imbued with the aegis of trust our MD affords, only to silently steal the lives of our patients. No patient or patient's family must ever have to worry that a stranger might come in the night and steal the life of a loved one, no matter how painful that life might be.

It is over for Debbie: whether or not she was prepared, whether or not her last words had been exchanged, whether or not the last visit had been made with a friend, sister or child, whether or not her family or doctors ever wanted it that way. It *is* over for Debbie. Let us hope it is far from over for the resident involved. This resident needs care and instruction at minimum, discipline for his or her own good and that of our profession, and possibly legal action. What residency program in good conscience would graduate this resident?

It's only beginning for us. A review of the literature suggests this is the first instance of an act of unsolicited, active killing of a patient by a physician presented as a case report of euthanasia in a juried medical journal. This is no way to begin a tradition of euthanasia or even a dialogue regarding euthanasia. This resident's identity must be revealed and corrective action taken promptly to ensure all observers that the medical profession will not tolerate this attitude and behavior and that no one need fear the physician who answers one's call at night. If this does not occur, it could easily be over for even more than Debbie.

Martha Keeney Heyburn, MD



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Memoir of Robert E. Pennington 1910-1988

by Paul R. Smith, MD



Physicians in Kentucky mourn the death of Dr. Robert E. Pennington of London. Bob Pennington was a gentleman of the old school. He will be remembered for his professionalism, his integrity, and his sense of appropriateness. He was a man with a keen mind, a quick wit, and a hardy laugh. Dr. Pennington engendered respect among his fellow workers and acquaintances. He was a strong leader and was well informed and knowledgeable in the task at hand. He was willing to help his colleagues both locally and on the state and national level. Dr. Pennington was a skilled surgeon with no tolerance for error. His father, Dr. H. V. Pennington, pioneered the practice of medicine in southeastern Kentucky. In 1926 he built the first building between Lexington and Knoxville that was built to be a hospital.

Many honors have come his way. Dr. Pennington served the KMA in numerous capacities, including Trustee, Chairman of the Board of Trustees, and President of KMA. In 1971, he received the Distinguished Service Award from KMA. He has served on numerous health planning committees, more notably on the comprehensive Health Planning Council for Kentucky, and on the Appalachian Regional Commission Health Advisory Council.

Following his medical training at the University of Pennsylvania, his surgery residency training at Mayo, and a tour of duty in World War II, he returned to London to practice general surgery. He continued the practice of surgery until 1979 at which time he closed his active practice to accept a position with the Veterans Administration Medical Center, Lexington. In 1984 he retired again and returned to London.

The Pennington legacy will continue with his son, Robert, Jr., who is a surgeon in Richmond, Indiana. In addition to his wife Carol, he has two daughters, Kathy and Sallie, both nurses, and a daughter, Thea, an accountant in Winchester.

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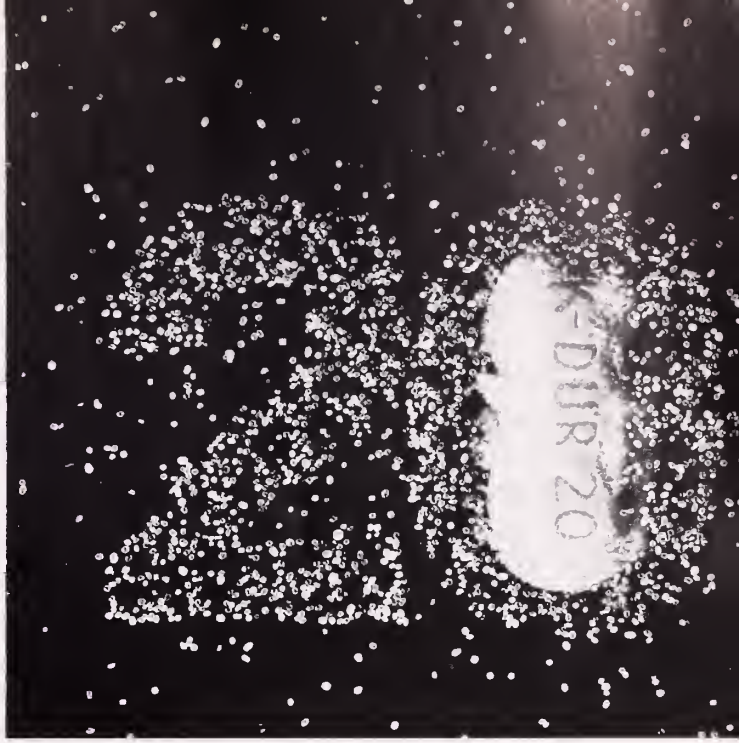
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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics, see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE**). There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS**); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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1988 Membership Phonathons Net Renewals and New Members

Three successful membership phonathons were conducted in April at the KMA office. On April 12, KMA Executive Committee members called physicians who had not yet renewed their membership for 1988. Participating in the fourth annual phonathon were: Donald C. Barton, MD; Bob M. DeWeese, MD; Nelson B. Rue, MD; S. Randolph Scheen, MD; William B. Monnig, MD; and John D. Noonan, MD.

Under the direction of the KMA Membership Committee, nonmember phonathons were held on April 13 and April 27. A total of 283 calls were attempted during the two sessions and the callers actually spoke with 135 nonmember physicians. Of that number, 97 or 72% indicated they were interested in becoming a member. According to Membership Committee Chairman, Harold D. Haller, Sr, MD, "A good number of those called really appreciated our contacts and the opportunity to talk with a member physician about issues affecting them. We feel we'll see some positive results from these efforts."

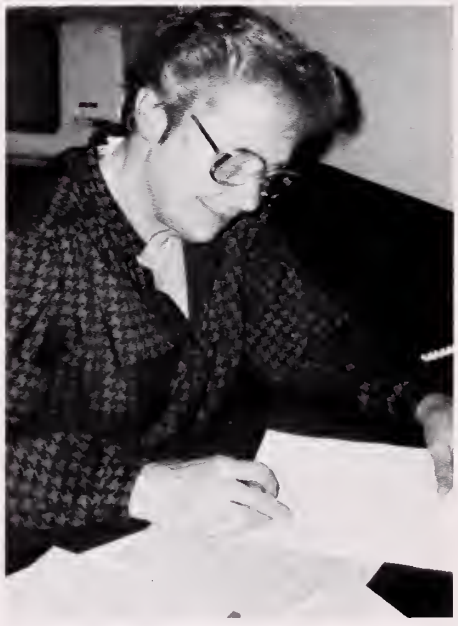
In addition to Doctor Haller, who participated in both phonathons, the recruiters were: Charles Allnutt, MD, Covington; Irene Roeckel, MD, Lexington; M. S. Viji, MD, Lexington; Syed Nawab, MD, Louisville; Gorden McMurry, MD, Louisville; John J. Whitt, MD, Louisville; and Lelan Woodmansee, JCMS Director, Louisville.



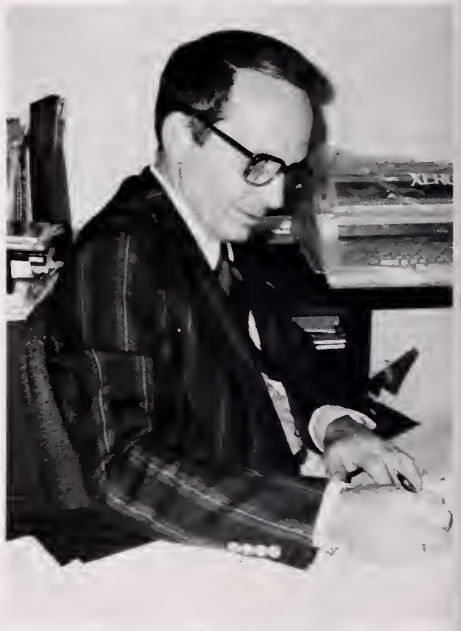
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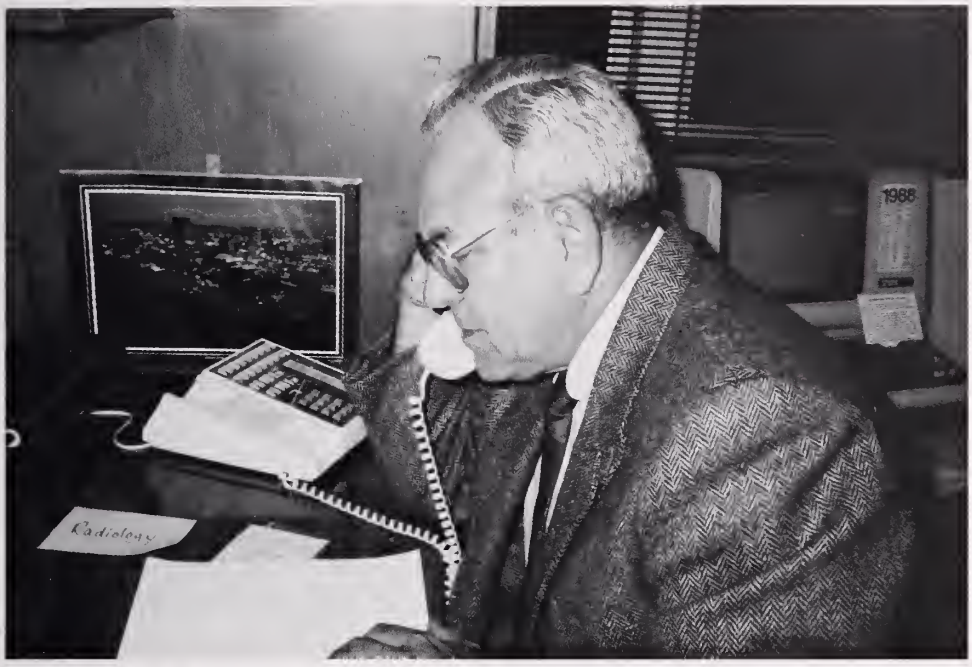
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Bob M. DeWeese, MD, Louisville



S. Randolph Scheen, MD, Louisville

KMA Night on KET

KMA Night on KET Telefund '88 was a success. During the evening of March 16, a record turnout of enthusiastic, volunteer physicians from KMA and the Fayette County Medical Society helped raise more than $16,500 in programming funds. This year marks the fifth consecutive year that KMA has participated in the fund drive.

The KMA group was represented on the air by President Donald C. Barton, MD.





President Barton accepted an award to KMA for its involvement in KET from Deputy Executive Director Sandy Welch.



"LET'S GIVE AMERICA THE FACTS"

A Medical Society Primer
for Effectively Communicating Information
About AIDS.

FOREWORD 313

CHAPTER ONE

FREQUENTLY ASKED QUESTIONS AND ANSWERS 314

CHAPTER TWO

GLOSSARY 326

CHAPTER THREE

AIDS REFERENCE LIST 329

CHAPTER FOUR

KMA REPORT ON AIDS 331

FOREWORD

In cooperation with the American Medical Association and the Department of Health and Human Services, the Kentucky Medical Association (KMA) is reprinting a portion of "Let's Give America the Facts," a booklet relating to AIDS education. During the 1988 Kentucky General Assembly the KMA printed and distributed similar information in a booklet designed for members of the Kentucky General Assembly.

The information will be helpful as you deal with your patients or respond to requests to participate in public or media forums.

If we can provide additional information or you wish to participate in the radio project of the Department of Health and Human Services relating to disseminating AIDS information, contact KMA Headquarters.

This is an opportunity for physicians, medical societies, or medical staffs to be prepared for a crucial role in leading America out of AIDS ignorance and into AIDS prevention and control.

CHAPTER ONE

FREQUENTLY ASKED QUESTIONS AND SUGGESTED ANSWERS

This chapter answers the most frequently asked questions about AIDS to assist you in briefing your spokespersons.

What is AIDS?

AIDS or Acquired Immunodeficiency Syndrome is a very serious condition characterized by a collapse of the body's natural immunity against disease. Because of this failure of the immune system, patients with AIDS are vulnerable to infections or cancers that usually do not pose a threat to anyone whose immune system is working normally. These diseases include Kaposi's sarcoma and a parasitic infection of the lungs called *Pneumocystis carinii* pneumonia.

What is HIV?

HIV stands for Human Immunodeficiency Virus and it is the viral agent involved in the development of AIDS or AIDS-Related Complex (ARC).

What causes AIDS?

AIDS is caused by a virus that attacks certain white blood cells that help protect the body from infections.

Human Immunodeficiency Virus (HIV) is now the commonly used term for the virus that causes AIDS. Different researchers in the past have given different names to the virus that is linked with AIDS: human T-lymphotropic virus, type III (HTLV-III); lymphadenopathy associated virus (LAV); or AIDS-related virus (ARV). Infection with this virus does not always lead to AIDS, although scientists now believe that everyone who is infected will develop some HIV-related illness, the most severe of which is AIDS. Researchers are investigating whether other cofactors may be necessary to trigger AIDS. AIDS can follow exposure to HIV and may be exacerbated by other viral infections, genetic predisposition, or a pre-existing immune system weakness. Preliminary studies show that some HIV-infected persons remain in good health for a period of years; others may develop illnesses varying in severity from mild to extremely serious.

Why is AIDS such a devastating disease?

Individuals with AIDS are vulnerable to secondary infections and rare diseases because the AIDS virus selectively attacks the "helper" T-lymphocyte or T-4 cell. This white blood cell is perhaps the single most important element in the body's defense against infection. Without this defense, people are vulnerable to innumerable diseases and infections.

Is AIDS present only in the United States?

AIDS cases have been reported from 50 states, the District of Columbia, Puerto Rico and more than 100 other countries. The disease has been recognized by the World Health Organization as a worldwide epidemic.

Where are the most cases of AIDS in the United States?

Currently, about half of the cases in the United States are reported from New York and California, followed by Florida, Texas, New Jersey, Illinois, Pennsylvania, Massachusetts, Georgia and the District of Columbia.

The cities where AIDS is most common are New York, San Francisco and Los Angeles, followed by Houston, Washington, D.C., Miami, Newark, Chicago, Dallas and Philadelphia.

Why are AIDS cases so heavily concentrated in a few cities, such as New York and San Francisco?

This clustering of cases is presumably related to the high concentration of sexually active gay men and IV drug abusers in these areas. The disease was well-established in these communities prior to its recognition in 1981.

Where did the AIDS virus come from?

Researchers do not know for certain where the AIDS virus came from, although in all likelihood it originated in equatorial Africa. It is a member of a group of viruses called lenti-viruses — the "slow" viruses that can leave victims free from symptoms years after infection.

What is the incubation period for AIDS?

The onset of symptoms following infection with the HIV virus is thought to range from six months to several years. Many people exposed to the virus have not developed AIDS, yet.

Antibodies to the AIDS virus, which are detected by a blood test, may take six weeks to three months to appear after exposure to the virus.

Does anybody ever survive AIDS?

Some people with AIDS are still alive for years after diagnosis. Since there is no known way to reverse the damage to the immune system, we don't know how long AIDS patients can live. Tracking of the disease has only been underway for about seven years, so we have no long-term records.

What is AIDS-Related Complex (ARC)?

Some people infected with the AIDS virus remain healthy and free of symptoms for months or years. Others develop ARC, the symptoms of which may include fatigue, weight loss, diarrhea, fever, chills, night sweats, and swollen glands. These symptoms last longer than they would in other illnesses, such as the flu.

People who develop AIDS may at first have the same symptoms as those with ARC, but they go on to develop rare, often fatal illnesses, including *Pneumocystis carinii* pneumonia, a parasitic infection of the lungs; and Kaposi's sarcoma, a type of skin cancer that appears as purplish patches often found on the skin or inside the mouth, nose, or eyelids.

It is important to know that ALL people infected with the AIDS virus — even those who remain completely free of symptoms — will likely be infectious their entire lives and able to pass the virus on to others.

What are some of the diseases affecting AIDS patients?

About 85% of the AIDS patients studied have had one or both of two rare diseases: *Pneumocystis carinii* pneumonia (PCP), a parasitic lung infection that causes symptoms similar to other forms of pneumonia; and/or a rare type of cancer known as Kaposi's sarcoma (KS), which usually occurs anywhere on the surface of the skin or in the mouth. AIDS patients also may develop unusually severe infections with yeast, cytomegalovirus, other herpes viruses and parasites such as *Toxoplasma* or *Cryptosporidia*; milder infections with these organisms do not suggest immune deficiency. About 30% of patients show symptoms of brain disease or other neurological disorders.

TRANSMISSION OF THE VIRUS

How is AIDS transmitted?

The AIDS virus is not transmitted by casual, non-sexual contact. It is spread by the exchange of blood, semen, or possibly vaginal secretions during sexual activity. The virus can also be spread through the exchange of blood through sharing contaminated intravenous drug needles and to infants born to infected mothers.

Prior to 1985, when screening of blood began, the AIDS virus also was spread through transfused blood or blood products. However, since the initiation of widespread screening of all donations, this risk has been greatly reduced.

How contagious is AIDS?

Unlike some transmissible diseases — colds, flu, measles, etc. — AIDS is not transmitted through sneezing, coughing, eating, or drinking from common utensils, or by merely being around an infected person. After seven years of experience, it is evident that casual contact with AIDS patients does not place others at risk. No cases have been found in which AIDS has been transmitted through casual (non-sexual) contact to a household member, relative, co-worker, or friend. Health workers and others who care for AIDS patients on a daily basis have not become infected, except following needlestick injuries or extensive exposure to blood or body fluids from an infected patient.

Can I get AIDS from oral sex?

AIDS is spread through sexual contact involving the exchange of body fluids. AIDS could be transmitted in the act of oral sex, if infected blood, semen, or vaginal secretions get into cuts or lesions in the mouth.

Can I get AIDS from vaginal sex?

Yes.

Can I get AIDS from anal sex?

Yes. The lining of the rectum is thinner and more easily torn than the thicker, protective lining of the vagina. Anal intercourse can therefore result in direct semen-to-blood exchange.

Can infected women pass the virus to men through sexual contact?

Yes, although there are only a handful of AIDS cases in the United States reported to clearly have been transmitted from women to men. These cases are still under investigation to identify the potential transmission route or to determine if other risk factors may be involved. Some experts believe that female-to-male transmission of AIDS through sexual contact is less likely to occur than male-to-female transmission.

Can prostitutes spread AIDS?

Prostitutes are likely carriers of HIV since they engage in sex with many partners and are often IV drug abusers. Anyone who engages in sex with a prostitute or an anonymous partner is increasing the risk of contracting AIDS.

Is there anything I can do to reduce my risk of contracting AIDS?

The Public Health Service recommends the following steps for all persons to reduce their chances of becoming infected with the virus that causes AIDS:

- Recognize that abstinence or mutual monogamy is the best protection against sexual transmission of the AIDS virus.
- Do not have unprotected sex, sex with multiple partners, or with persons who have had multiple partners (especially prostitutes). The more partners you have, the greater your risk of exposure.
- Do not have unprotected sex with partners who have AIDS, persons who have engaged in high-risk behavior, or persons who have a positive antibody test for the virus. Protect yourself during intercourse by using a latex condom from start to finish. The use of a spermicide containing nonoxynol-9 may also further reduce the risk of transmitting the AIDS virus.
- Avoid sexual activities that could cause cuts or tears in the lining of the rectum, vagina, or penis, such as anal intercourse.
- Do not have sex with male or female prostitutes; drug abuse is common among prostitutes.
- If you do not know the sexual history of your partner, or whether he or she may have used illegal intravenous drugs, use condoms and a spermicide to reduce the possibility of being exposed to the virus.
- Do not share needles or syringes with anyone.

Will using a condom prevent the transmission of the AIDS virus?

Using a condom during sex probably reduces the risk of AIDS since it minimizes direct contact with semen, a body fluid known to carry HIV in infected persons. But condoms can fail; they do not provide guaranteed protection against infection.

Will any other birth control other than condoms help prevent AIDS?

No. Condoms prevent the exchange of bodily fluids that might harbor the AIDS virus. The pill, diaphragm and IUD do not.

If I am having elective surgery, should I donate my own blood?

Donating your own blood for use during planned elective surgery is strongly recommended.

Why are IV drug users at higher risk for AIDS?

Intravenous drug abusers often share needles for drug injection which can result in small amounts of blood from an infected person being injected directly into the bloodstream of the next user.

Drug abusers are being urged not to share needles or other drug injection equipment and to enter drug treatment programs to become drug-free.

MYTHS

Can I get AIDS from drinking from the same glass or eating from the same dishes as a person with AIDS?

Can I get AIDS from public toilets?

Can I get AIDS from drinking fountains?

Can I get AIDS from telephones or public transportation?

Can I get AIDS from touching or hugging someone with AIDS?

Can I get AIDS from a swimming pool?

Can I get AIDS from being in the same house with a person with AIDS?

Can I get AIDS from casual (non-sexual) contact with a gay friend or co-worker?*

Can I get AIDS from eating in a restaurant where someone with AIDS is working as a cook or waiter?

Can I get AIDS by going to the same barber as someone with AIDS?

The answer to all of these questions is "NO." The AIDS virus is not spread through the air, in food, or by touching any object handled, touched, or breathed on by an AIDS patient or by casual contact at home, at work, or in school. Associating with people who have AIDS or with individuals who practice high risk behaviors, does not pose any risk of contracting the disease.

*Note: If a gay friend or co-worker is not HIV-infected, then the answer is "no" regardless of type of contact.

Can I get AIDS at the gym where I work out if someone with AIDS works out too?

No. You cannot get AIDS from sweat.

Can I get AIDS from mosquitoes?

There is no evidence that the virus is transmitted by mosquito or other insect bites. Unlike diseases that are transmitted by mosquitoes, such as malaria and yellow fever, the AIDS virus does not infect the mosquitoes' salivary glands.

Can I get AIDS from my cat?

No. The disease feline leukemia, which is similar to a form of leukemia in humans, is not AIDS and you cannot get this disease or AIDS from your cat.

Can I get AIDS from donating blood?

No. All of the needles, syringes, tubing and containers used by blood donation centers are sterile, used only once and thrown away — there is no chance of infection. No one should fear getting AIDS from donating blood. There is no chance of getting AIDS in this way, and the need for blood to save lives is great.

Can I get AIDS from a blood transfusion?

Today, the risk of getting AIDS from a blood transfusion has been greatly reduced. All donated blood and blood products are tested for the AIDS virus antibody, and donors are screened for risk factors. The risk of getting AIDS from a blood transfusion has always been small. Only 2% of all cases of AIDS have resulted from blood transfusions. Another 1% of cases have been hemophilia patients who received blood clotting factor concentrates to treat their disease. Almost all of these cases were infected before blood screening was begun.

Can I get AIDS from French kissing?

It is not probable and no cases of transmission have been reported in this way. However, the virus has been isolated in saliva and deep kissing must be considered to have some risk, particularly if there are cuts or sores in the mouth of both partners.

Is it true that mostly blacks and Hispanics are getting AIDS?

No. Overall, black and Hispanic adults with AIDS don't number as high as the incidence in white adults. However, nearly 80% of all children with AIDS are either black or Hispanic. Seventy percent of the black women and 83% of the Hispanic women with AIDS are drug abusers or the partners of drug addicts. In the case of minority men with AIDS, 40% of black and Hispanic men abuse drugs.

RESEARCH, VACCINES, CURES

What are the greatest challenges in AIDS research today?

Researchers have discovered that the AIDS virus changes or mutates very rapidly. As the virus changes its protein coat, the creation of an effective vaccine against any one type of the AIDS virus may not be effective against other types.

Another problem in AIDS research is that there are no animal models for use in testing AIDS. Only human beings get AIDS and die. Animals such as white mice and laboratory rats are not even infected when exposed to the AIDS virus. Chimpanzees are the only animals that register an infection from the AIDS virus, but they do not become ill. Consequently, any vaccine that might be developed will have to be tested on humans, and that will present some difficult ethical dilemmas.

Is there a vaccine to prevent AIDS?

There is currently no vaccine to protect a person from the AIDS virus. Researchers in the United States and other countries are working diligently to develop an AIDS vaccine.

Is there a cure?

There is no cure for AIDS or for infection with the AIDS virus. Some of the infections associated with the disease can be treated, however, and some anti-viral agents are promising in their ability to control the virus inside the body and to prevent or delay the onset of more severe symptoms of AIDS.

What drugs have been approved and why?

The Food and Drug Administration can approve a new drug once data have been submitted verifying the drug is safe and effective for the indication. In the case of AIDS, AZT (now called zidovudine) has been approved as a treatment for AIDS because it has clearly demonstrated an ability to prolong the survival of certain AIDS patients with advanced secondary infections and diseases.

What is the current drug approval process?

The Food and Drug Administration has given all potential AIDS drugs a 1-AA classification in the Center for Drugs and Biologies' drug priority classification system. This assures them the very top priority in the agency's review process. The agency's expedited review of AZT, which became the first approved treatment for AIDS, served as the prototype for the new 1-AA classification.

HEALTH-CARE WORKERS

Are health-care workers at risk for AIDS?

A very small number of health-care workers (a total of 12 reported as of August 1987) have developed antibodies to the AIDS virus — indicating infection — as a result of needlestick injuries or exposure to blood or body fluids through broken skin. These cases represent very rare events; however, they emphasize the need for health-care workers to strictly follow existing recommendations for minimizing the risk of exposure to patients' blood and body fluids.

Is it all right for a doctor to refuse to treat an AIDS patient?

According to a recent AMA position, a physician may not ethically refuse to treat a patient whose condition is within the physician's current realm of competence solely because the patient is HIV-positive. Patients with the AIDS virus should not be subjected to discrimination based on fear or prejudice. Physicians who are unable to provide the services required by AIDS patients should make referrals to those physicians or facilities equipped to provide them.

What is being done to protect members of the health-care profession?

The Public Health Service has developed recommendations and guidelines for health-care workers and other occupational groups that come into contact with AIDS patients or specimens in their work. The most recent recommendations emphasize the need for health-care workers to use blood and body fluid precautions for all patients, not just those known or suspected of being infected. The Occupational Safety and Health Administration is beginning a program of enforcement to ensure that appropriate safeguards are provided in health-care settings.

What safety protocols have been developed for health-care professionals?

Health-care professionals who may come into contact with AIDS patients are being instructed in safety precautions to prevent direct contact with blood and body fluids. Safety guidelines have been developed for all health-care workers including doctors, nurses, dentists, laboratory personnel, ambulance personnel, funeral directors, prison personnel and emergency care personnel.

Should a doctor who has AIDS or who tests positive continue to treat patients?

A physician who knows that he or she is positive should not engage in any activity that creates a risk of transmission of the virus to others. The physician should consult colleagues as to which activities the physician can pursue without creating a risk to patients.

WORKPLACE ISSUES

Can you be fired because you have AIDS?

Public health officials advise that there is no reason to exclude AIDS patients from employment as long as they feel well enough to work. Persons who believe they are being discriminated against by employers should seek help from the American Civil Liberties Union, their local health department, or private counseling centers.

What legal rights do people with AIDS have?

They have the same rights as those accorded to any other ill member of our society. Unfortunately, discriminatory action has been taken against some AIDS patients by employers, landlords, neighbors, co-workers, and others who are apparently acting out of unwarranted fears based on misinformation.

Is it right to keep secret the identity of a person with AIDS?

Since AIDS does not pose a risk to the general public, there is no need for neighbors, shopkeepers, co-workers, or others who may have casual contact with a person with AIDS to know.

Who pays for treatment of AIDS victims?

Care for AIDS patients is paid for by the same means as all medical care: the government (Medicaid and Medicare), insurance companies and individuals. Most insurance policies cover AIDS medical treatment, though most have maximum allowances. The cost of care for an AIDS patient ranges from $20,000 to more than $100,000, depending on the severity of illness and how long the patient lives.

Can funeral directors refuse to embalm victims of AIDS?

While some funeral establishments have refused to accept anyone who has died of an AIDS-related illness, there are sufficient firms available who will do so.

AIDS AMONG WOMEN AND CHILDREN

How do women get AIDS?

Most women who develop AIDS have a history of illicit IV drug abuse, and presumably contracted the virus through the sharing of needles. Others have gotten AIDS through sexual contact with a man who has AIDS or is infected with HIV. Some women have developed AIDS following a blood transfusion prior to 1985, when mandatory testing of all blood was instituted. A very few have been patients with hemophilia who were infected by the blood clotting factor used to treat their disorder.

Can a pregnant woman pass the AIDS virus to her unborn child?

Women who are engaging in IV drug abuse or are sexual partners of infected men are being advised that if they are infected and become pregnant they can pass the virus to their child. The federal Centers for Disease Control has recommended that high risk women of child bearing age obtain voluntary, confidential HIV antibody testing to determine their health status prior to becoming pregnant.

How do children get AIDS?

Some 80% of all children with AIDS were infected during pregnancy or at the time of delivery; 12% received transfusions of infected blood before the blood supply was protected; and 5% are hemophiliacs who were treated with blood products before the need to destroy the virus was known.

Can children with AIDS pass it on to other children?

Children do not spread infection to other children or their care givers through ordinary, everyday casual contact. Transmission would require direct exposure of a child's bloodstream to blood from an infected child.

Can my child get AIDS if he is bitten by a child with AIDS?

There have been no documented cases of AIDS transmitted through biting, since saliva is not nearly as hospitable a host to the virus as are semen and blood. It is theoretically possible, but highly unlikely.

Should children with AIDS attend school?

The Public Health Service recommends that, except in very unusual circumstances, children with AIDS "should be allowed to attend school and after-school day care and to be placed in a foster home in an unrestricted setting."

Is there danger of a child's contracting AIDS from friends or schoolmates?

No. The AIDS virus is difficult to catch, even among people at highest risk for the disease. No cases of AIDS are known or suspected to have been transmitted from one child to another in school, day care, or foster-care settings.

What risk does mixing with other children pose to a child with AIDS?

Immune-suppressed children are highly susceptible to infections from other children in a school or day-care setting. Assessment of risk to an immune-suppressed child from attending school is best made by the child's physician, who is aware of the child's immune status.

Can children develop AIDS from mother's milk?

There are a few cases of AIDS in which the suspected mode of transmission is breast feeding. Any woman who is positive for HIV antibodies is advised to refrain from nursing as a precautionary measure.

SYMPTOMS AND TREATMENT

How can I tell if I am infected?

There may be no symptoms of HIV infection; therefore, you may be unaware that you are infected. In this case, only the HIV antibody blood test will tell you if you have ever been infected with the virus. After infection has occurred, it may take between six weeks and three months or longer to produce antibodies. That is why certain people — those who have engaged in high-risk behavior and have reason to believe they may have been exposed to the virus — are encouraged to repeat their test in six months.

What are the symptoms of AIDS?

The symptoms of AIDS are non-specific and may be the same as in other illnesses such as a cold or the flu. In its early stages, immune deficiency may not cause any symptoms. The symptoms that persons with AIDS eventually develop are related to the disease or infections that attack them because of their inability to fight off infection. However, if the following symptoms persist, a physician should be consulted:

- Prolonged fatigue that is not explained by physical activity or by other disorders.
- Unexplained swollen glands.
- Persistent fevers or night sweats.
- Unexplained weight loss of more than ten pounds during a period of less than two months.
- Recent appearance of purplish or discolored lesions of the skin or mucous membranes that do not go away.
- A persistent, unexplained cough.
- Thrush, which is a whitish coating on the tongue or in the throat.
- Easy bruising or unexplained bleeding.
- Progressive shortness of breath.
- Continuous bouts of diarrhea.

How is AIDS treated?

Though no treatment has yet been successful in restoring AIDS patients' immune systems, doctors have had some success in using drugs, radiation, and surgery to treat the various illnesses AIDS patients suffer.

Currently there are no drugs available anywhere that have been shown to cure AIDS, although the search for an effective treatment is being pursued vigorously. Treatment is directed at the specific opportunistic infections or cancers which attack AIDS patients.

Zidovudine (AZT) has been shown to prolong life and relieve symptoms of illness in some AIDS patients and has been approved for use in certain patients. It does **not**, however, cure AIDS.

Where are AIDS patients treated?

AIDS patients are treated in hospitals, physician's offices, clinics or other health-care settings, just like any other patients. AIDS patients do not pose a risk to other patients or to health-care workers who follow recommended safety precautions.

THE TEST

Is there a test for AIDS?

There is no single test for diagnosing AIDS. There is, however, a test that detects antibodies (a substance produced in the blood to fight disease organisms) to the virus that causes AIDS.

The test is called an ELISA (Enzyme Linked ImmunoSorbent Assay) test. If the ELISA test is positive, a second ELISA test, and then another test, usually the Western Blot, is run on the same blood sample to confirm the result. Since all tests yield some proportion of false positive and false negative results, more accurate tests are being developed for detection of the antibody and the virus itself. However, currently available tests, used as described, give extremely reliable results.

The presence of antibodies to the AIDS virus means that a person has been infected with that virus but does not necessarily mean that the person has developed or will develop AIDS. When a person is infected, it may take from six weeks to three months for antibodies to appear in the blood. Even if someone has a negative test for antibodies, it is still very important to avoid high-risk behaviors.

Who should be tested?

Testing for the AIDS virus should be **mandatory** for four specific groups of people:

- Blood donors and donors of semen or ova collected for artificial insemination.
- Immigrants to the United States.
- Inmates in federal and state prisons.
- Military personnel.

Further, **voluntary** testing should be regularly provided for individuals who give an informed consent and who are included in these five groups:

- Patients at sexually transmitted disease clinics.
- Patients at drug abuse clinics.
- Pregnant women in high-risk areas in the first trimester of pregnancy.
- Individuals seeking family planning services who are from areas with a high incidence of AIDS or who engage in high-risk behavior.
- Patients requiring surgical or other invasive procedures who are from areas with a high incidence of AIDS or who engage in high-risk behavior. If the voluntary policy is not sufficiently accepted, the hospital and medical staff should consider a mandatory program for the institution.

How is AIDS diagnosed?

Infection with the AIDS virus is indicated by the presence of antibodies to the virus in the blood. The diagnosis of AIDS depends on the presence of secondary diseases that indicate the loss of immunity. Tests demonstrating damage to various parts of the immune system, such as a decrease in the number of certain white blood cells (T-4 lymphocytes), support the diagnosis.

Is the AIDS antibody test confidential?

Confidentiality for those who choose to be tested is, of course, a very important concern. In many testing centers, the test is done anonymously (using a number instead of a name), so that only the person tested knows the result.

Can a doctor notify the spouse or partner of someone who tests positive for the AIDS virus?

Physicians are ethically obligated to respect the rights of privacy and of confidentiality of AIDS patients and HIV-positive individuals. Where there is no law that mandates or prohibits the reporting of seropositive individuals to public health authorities, and a physician knows that the individual is endangering someone else, the physician should:

- Attempt to persuade the infected patient to cease endangering the other person.
- If persuasion fails, notify authorities.
- If the authorities take no action, notify the endangered person.

Should I have the test?

You may not be able to answer this question without guidance or counseling. Your physician is probably the most appropriate one to help you explore whether or not you could have been exposed to HIV and, therefore, if the test is in order.

You should be tested, however, if you:

- Received a blood transfusion between 1977 and March 1985.
- Engage in high-risk sexual behavior, such as unprotected intercourse with a partner who may have been exposed to the virus. (Anal intercourse is thought to be one of the most common ways in which the virus is transmitted.)
- Use intravenous drugs and share needles.
- Have unprotected sex with a partner who fits into one of the above groups.

Where can I get the blood test and how much will it cost?

The test is available at what are called "alternative test sites." They can offer anonymous and free or low-cost testing, but you should find out the specifics from each site. To find one near you, you can call the National AIDS Hotline at 1-800-342-AIDS or check with your local public health department. The test generally costs $50 or $60, but can range from no cost to $100.

If I donate blood, will it be screened?

All donor blood collected by the American Red Cross and other blood donation centers has been tested for the AIDS antibody since the test was licensed in the spring of 1985. A preliminary test is taken on each unit donated. If positive, a second test is made. If the tests are repeatedly reactive, the Western Blot confirmatory test is performed. No units that test positive are used for transfusions. All donors are notified if the Western Blot test is positive for the AIDS antibody.

What does a positive blood test result mean?

It could mean:

- You have antibodies to HIV and can pass the virus on to other people, though you may show no signs of illness.
- You have a false positive result and have never been infected with HIV.

If I have been infected with HIV, will I develop ARC or AIDS?

Current evidence indicates that a history of HIV infection alone will not predict your future health. You may remain healthy for years with HIV antibodies in your body, although scientists now believe that everyone who is infected will eventually develop some HIV-related illness, the most common of which are ARC and AIDS. It is important to remember that if you have been infected with the AIDS virus, you can transmit it to others, even if you have no symptoms and feel perfectly well.

What are the chances of getting a false positive test?

The chances are very small, but false positives do occur. If the blood sample is positive on the first test, another confirmatory test called a Western Blot will be performed on the same sample of blood. If the Western Blot is positive, the likelihood of your positivity being false is remote.

What should I do if my antibody test results are positive?

- Seek regular medical evaluation and follow-up.
- Either avoid sexual activity or inform your prospective partner of your antibody test results and protect him or her from contact during sex. Use a latex condom from start to finish, and avoid sexual practices that may injure body tissues, such as anal intercourse.
- Inform any previous sex partners and any persons with whom you may have shared needles of their potential exposure to the AIDS virus. Encourage them to seek counseling and antibody testing from their physicians or from appropriate health clinics.
- Do not share items that could become contaminated with blood.
- If you use drugs, enroll in a drug treatment program. Needles and other drug equipment must never be shared.
- Clean blood off household or other surfaces with freshly diluted bleach — one part bleach to 10 parts water. Hot water and soap or other disinfectants may also be used.
- Inform your doctor, dentist and eye doctor of your positive antibody status so they can take proper precautions to protect you and others.
- If you're a woman with a positive antibody test, avoid pregnancy because of the high risk of transmission to your baby.

What does a negative test result mean?

It could mean:

- You have not been infected with HIV.
- You are infected, but your body has not yet produced antibodies to the virus, so you could still pass the HIV virus on to other people. The test may be negative in a person who has been infected in the past six to 12 weeks but whose antibodies have not had time to develop.
- You have been infected with the HIV virus, but it is a false negative test.

What are the chances of getting a false negative result?

The HIV antibody test was designed to make more false positive errors than false negative errors (in the effort to keep the nation's blood supply free of contaminated blood). The chance for a false negative result is extremely remote.

CHAPTER TWO

GLOSSARY

ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) — A severe manifestation of infection with human immunodeficiency virus (HIV).

AIDS-RELATED COMPLEX (ARC) — A variety of chronic symptoms and physical findings that occur in some persons who are infected with HIV but do not meet the Centers for Disease Control's definition of AIDS. Symptoms may include chronic swollen glands, recurrent fevers, unintentional weight loss, chronic diarrhea, lethargy, minor alterations of the immune system (less severe than those that occur in AIDS), and oral thrush. ARC may or may not develop into AIDS.

ANTIBODY — A protein belonging to a class of proteins called immunoglobulins. Antibodies are produced by plasma cells to counteract specific antigens (infectious agents like viruses, bacteria, etc.). The antibodies then combine with the antigens they are made to fight and often cause the death of that infectious agent.

ANTIGEN — A substance (often a protein or carbohydrate on the surface of an infectious agent) foreign to the body that stimulates the formation of antibodies to combat its presence.

B-LYMPHOCYTE (OR B-CELL) — A type of white blood cell that floats through the body and is able to detect the presence of foreign agents. Once exposed to an antigen on the agent, these cells differentiate into plasma cells to produce antibodies.

CASE-CONTROL STUDY — A design for epidemiologic studies that matches individuals with a disease or health problem (cases) with others who do not have that condition (controls). Frequently, individuals included in the study are matched for factors such as age, race, socioeconomic status, occupation and area of residence. Comparisons are then made between the two groups.

CASUAL CONTACT — Refers to day-to-day interaction between HIV-infected individuals and others in the home, at school or in the work place. It does not include intimate contact, such as sexual or drug-use interactions, and it implies closer contact than chance passing on a street or sharing a subway car.

CELL-MEDIATED IMMUNITY — A defense mechanism involving the coordinated activity of two subpopulations of T-lymphocytes, helper T-cells and killer T-cells. Helper T-cells produce a variety of substances that stimulate and regulate other participants in the immune response. Killer T-lymphocytes destroy cells in the body that bear foreign antigens (e.g., cells that are infected with viruses or other microorganisms).

COFACTOR — A factor other than the basic causative agent of a disease that increases the likelihood of developing that disease. Cofactors may include the presence of other microorganisms or psychosocial factors such as stress.

CONDOM — A rubber sheath worn over the erect penis during intercourse to prevent pregnancy or sexually transmitted disease.

DISSEMINATION — Spread of the disease throughout the body — usually through the blood.

DNA (DEOXYRIBONUCLEIC ACID) — A nucleic acid found chiefly in the nucleus of living cells that is responsible for transmitting hereditary characteristics.

EJACULATION — The release of semen, usually at the climax of the sexual act.

ELISA — An acronym for "enzyme-linked immunosorbent assay," a test used to detect antibodies against HIV in blood samples.

ENZYME — Usually a protein made by the body to make chemical reactions take place at a faster rate or to cause a color change in a laboratory test.

FALSE NEGATIVE — A negative test result for a condition that is, in fact, present.

FALSE POSITIVE — A positive test result for a condition that is not, in fact, present.

HEMOPHILIA — A rare, hereditary bleeding disorder of males, inherited through the mother, caused by a deficiency in the ability to make one or more blood-clotting proteins.

HERPES SIMPLEX VIRUS I (HSV I) — A virus that results in cold sores, or fever blisters, most often on the mouth or around the eyes. Like all herpes viruses, the virus may lie dormant for months or years in nerve tissue and flare up again under stress, trauma, infection or immuno-suppression. There are no cures for any of the herpes viruses.

HERPES SIMPLEX VIRUS II (HSV II) — The virus causing genital herpes infections. Infection usually results in painful sores on the genitals or anus. It is one of the most common sexually transmitted diseases in the United States.

HERPES VIRUS GROUP — A group of viruses that includes the herpes simplex viruses, the varicella-zoster virus (the cause of chicken pox and shingles), cytomegalovirus and Epstein-Barr virus.

HETEROSEXUAL — An individual who is sexually attracted to persons of the opposite sex.

HIV (HUMAN IMMUNODEFICIENCY VIRUS) — The name proposed for the causative agent of AIDS by a subcommittee of the International Committee on the Taxonomy of Viruses.

HOMOSEXUAL — An individual who is sexually attracted to persons of the same sex.

IMMUNE STATUS — The state of the body's natural defense to fight diseases. It is influenced by age, past illness history, diet and physical and mental health, and includes production of circulating and local antibodies and their mechanism of action.

IMMUNE SYSTEM — The natural system of defense mechanisms in which specialized cells and proteins in the blood and other body fluids work together to eliminate disease-producing microorganisms and other foreign substances.

IMMUNOSTIMULANT — Any agent that will trigger a body's defenses.

IMMUNOSUPPRESSED — A state of the body where the immune system defenses do not work normally. This can be the result of illness or the administration of certain drugs (commonly ones used to fight cancer).

INTERFERON — An antiviral chemical secreted by an infected cell which strengthens the defenses of nearby cells not yet infected.

INTERLEUKIN-2 — A substance produced by T-lymphocytes that stimulates activated T-lymphocytes and some activated B-lymphocytes to proliferate. Also known as T-cell growth factor.

INTRAVENOUS — Injected into or delivered through a needle in a vein.

KAPOSI'S SARCOMA — A cancer or tumor of the blood and/or lymphatic vessel walls. It usually appears as blue-violet to brownish skin blotches or bumps. Before the appearance of AIDS, it was rare in the United States and Europe, where it occurred primarily in men over age 50 or 60, usually of Mediterranean origin. AIDS-associated Kaposi's sarcoma is much more aggressive than the earlier form of the disease.

LEUKOCYTE — A white blood cell.

LYMPHADENOPATHY — Enlargement of lymph nodes.

MACROPHAGE — A type of white blood cell that has the capacity to ingest or phagocytize foreign particulate matter, such as bacteria.

MONOCYTE — A phagocytic white blood cell that engulfs and destroys bacteria and other disease-producing microorganisms. It produces Interleukin-1, a substance that activates T-lymphocytes in the presence of antigen.

OPPORTUNISTIC INFECTIONS (OI) — A variety of diseases which occur in individuals who do not have healthy immune systems. These are microorganisms which do not usually cause diseases in a healthy individual. The OI seen in AIDS patients include *pneumocystis carinii* pneumonia, massive or overwhelming herpes infections, atypical microbacteria, toxoplasmosis or chronic or overwhelming candidiasis.

***PNEUMOCYSTIS CARINII* PNEUMONIA (PCP)** — A form of pneumonia caused by the protozoan *Pneumocystis carinii*, which appears in people with suppressed immune systems. Symptoms include lowgrade, persistent and unexplained fever, shortness of breath and a dry cough.

POSITIVE TEST — A sample of blood that is reactive on an initial ELISA test, repeatedly reactive on a second ELISA run of the same specimen, and reactive on Western blot, if available.

PREDICTIVE VALUE POSITIVE (PVP) — This is defined as the probability that a person with a reactive test has the disease and is not a false reactive.

PREDICTIVE VALUE NEGATIVE (PNP) — This is defined as the probability that a person with a negative test is free of the disease and is not a false negative.

PREVALENCE — The total number of persons in a given population with a disease at a given point in time. Prevalence is usually expressed as the percentage of persons with the disease in the population.

RETROVIRUS — A group of RNA viruses which are well-established to cause a variety of diseases in animals. A certain retrovirus (called human T-lymphotrophic virus type III or HLTV-III) has recently been implicated as the cause of AIDS and another as the cause of a rare type of leukemia.

REVERSE TRANSCRIPTASE — An enzyme produced by retroviruses that allows them to produce a DNA copy of their RNA. This is the first step in the virus's natural cycle of reproduction.

RNA (RIBONUCLEIC ACID) — A nucleic acid associated with the control of chemical activities inside a cell. One type of RNA transfers information from the cell's DNA to the protein-forming system of a cell outside the nucleus. Some viruses carry RNA instead of the more familiar genetic material DNA.

SENSITIVITY — The probability that the test will be positive when infection is present.

SEROCONVERSION — The initial development of antibodies specific to a particular antigen.

SEROPOSITIVE — In the context of HIV, the condition in which antibodies to the virus are found in the blood.

SPECIFICITY — The probability that the test will be negative when the infection is not present.

SPERMICIDE — A chemical agent inserted in the vagina that kills sperm.

SUBUNIT VACCINE — A vaccine that contains only portions of a surface molecule of a disease-producing microorganism.

SYNDROME — A pattern of symptoms and signs, appearing one by one or simultaneously, that together characterize a particular disease or disorder.

T-HELPER CELLS — A type of T-lymphocyte which assists the B-lymphocytes in producing antibodies.

T-LYMPHOCYTES (OR T-CELLS) — White blood cells that have matured in the thymus gland. There are two kinds of T-lymphocytes: helpers and suppressors. In AIDS, the number of helper cells is decreased.

T-SUPPRESSOR CELLS — a type of T-lymphocyte that stops antibody production when the invading antigen has been inactivated.

Glossary terms are defined according to the Centers for Disease Control and excerpted from the National Academy of Sciences' *Confronting AIDS: Directions for Public Health, Health Care and Research*; the American Medical Association's *Human Sexuality*; and James and Stephen McCary's *McCary's Human Sexuality*.

Glossary reprinted from "AIDS: A Guide for Survival" with permission of the Harris County (TX) Medical Society.

CHAPTER THREE

AIDS REFERENCE LIST

KENTUCKY AIDS RESOURCES

These organizations have publications and educational resources available upon request. Contact the individual organizations for listings, costs and ordering information.

Kentucky Department for Health Services
Kentucky AIDS Project
275 E. Main Street
Frankfort, KY 40621
502-564-4478

Act Lexington, Inc.
Lexington/Fayette County
Health Department
P.O. Box 11442
Lexington, KY 40575
606-252-2371

AIDS Crisis Taskforce—Lexington
P.O. Box 11442
Lexington, KY 40575
606-281-5151

Community Health Trust, Inc.
P.O. Box 363
Louisville, KY 40201
502-636-3341

Louisville-Jefferson County
Health Department
Specialty Clinic
834 E. Broadway
Louisville, KY 40204
502-587-3895

Northern Kentucky AIDS Task Force
401 Park Avenue
Newport, KY 41071
606-491-6611

NATIONAL AIDS RESOURCES

American College Health Association
15879 Crabbs Branch Way
Rockville, MD 20855
(301) 963-1100

American Red Cross
AIDS Education Office
1730 D Street NW
Washington, DC 20006
(202) 737-8300

American Social Health Association
P.O. Box 13827
Research Triangle Park, NC 27709
(415) 321-5134

Centers for Disease Control
Office of Public Inquiries
Building 1, Room B-63
1600 Clifton Road
Atlanta, GA 30333
(404) 329-2891

National AIDS Network
729 Eighth Street SE, Suite 300
Washington, DC 20003
(202) 347-0390

National Council of Churches/
AIDS Task Force
475 Riverside Drive, Room 572
New York, NY 10115
(212) 219-8180

National Technical Information Services
U.S. Department of Commerce
5285 Port Royal Road
Springfield, VA 22161
(703) 487-4650
(703) 487-4650

U.S. Public Health Service
Public Affairs Office
Hubert H. Humphrey Building, Room 725-H
200 Independence Avenue SW
Washington, DC 20201
(202) 472-4248

NATIONAL TOLL-FREE HOTLINES

The Public Health Service's National AIDS Hotline:	
Recorded Information	800-342-AIDS
Answers to specific questions	800-342-7514
National Gay Task Force AIDS Hotline	800-221-7044
National STD (Sexually Transmitted Diseases) Hotline	800-227-8922
AZT Hotline	800-843-9388
Project Inform Hotline (information on experimental drugs)	800-334-7422

NATIONAL HOTLINES

National Lesbian and Health Foundation (Washington, DC)	202-797-3706
Whitman-Walker Clinic (Washington, DC)	202-332-5295
AIDS Resource Center (New York, NY)	212-206-1414
Minority Task Force on AIDS (New York, NY)	212-749-1214

ADDITIONAL INFORMATION

The American Red Cross has over 3,000 chapters nationwide. These chapters play an important role in public education and information dissemination on the subject of AIDS. They have available a wide range of resource materials on AIDS for the public.

In addition, nearly 700 of the Red Cross chapters have AIDS coordinators who provide a wide variety of AIDS-related services, including counseling, panel presentations, and various assistance programs.

To contact your local Red Cross chapter, consult your local telephone directory.

For a free copy of the U.S. Surgeon General's Report on Acquired Immune Deficiency Syndrome (AIDS), call 404-329-3534, or write AIDS, P.O. Box 14252, Washington, DC 20044.

CHAPTER FOUR

REPORT OF THE KENTUCKY MEDICAL ASSOCIATION AD HOC COMMITTEE ON THE DEVELOPMENT OF AIDS GUIDELINES

The Ad Hoc Committee on the Development of AIDS Guidelines was appointed to establish a position on Acquired Immunodeficiency Syndrome (AIDS) for the Kentucky Medical Association, which might also be used as a basis for proposed legislation.

The Kentucky General Assembly's Committee on Health and Welfare has been considering public policy issues related to AIDS, and at a meeting in June, Nelson B. Rue, MD, Chairman, KMA Board of Trustees, from Bowling Green, and Ardis D. Hoven, MD, an infectious disease specialist from Lexington, offered testimony and addressed specific issues posed by that Committee. At this meeting Doctor Rue advised that he would ask KMA to develop a policy on AIDS. Doctor Hoven was subsequently asked to Chair a Committee composed of: Reginald Finger, MD, MPH, with the Communicable Disease Branch of the Department for Health Services in Frankfort; and Jayne L. Hollander, MD, Director, Louisville Region of the American Red Cross Blood Service.

The Committee developed the following formal replies to the questions posed by the legislative committee, as well as a document entitled "AIDS Policy Issues," which is attached. These materials are being submitted for approval and subsequent referral to the Health and Welfare Committee. As part of its work, the Committee has also developed an informational document entitled "AIDS Guidelines for Physicians." Because of the length of this document, it is not being disseminated at this point, but will be available on request.

Response to the Interim Joint Committee on Health and Welfare

The Kentucky Medical Association recognizes the medical threat that the infectious disease Acquired Immunodeficiency Syndrome (AIDS) poses to our population, and also recognizes the growing concern of the State's citizens with the spread of this disease. The prevention of the transmission of AIDS must be afforded the greatest priority. In developing the following materials and recommendations, KMA reviewed scientific data related to AIDS, epidemiology, transmission, and prevention.

Of paramount importance is the rational, sensitive, and scientific approach to an infectious disease for which currently there is no known cure, but for which preventive measures are well recognized. KMA has developed a document entitled, "AIDS Policy Issues." This document addresses in some detail issues related to AIDS that have been discussed by the Subcommittee. KMA has also endorsed the "Interim Report on the Prevention and Control of AIDS" developed by the American Medical Association at its June 1987 meeting. The AMA document addresses and gives background information on policy issues of concern to all segments of society. An informational document, "AIDS Guidelines for Physicians," was also developed and is available upon request from the Kentucky Medical Association.

The following recommendations regarding AIDS policy are offered to the Health and Welfare Committee by KMA.

1. The statutory and regulatory mechanisms for reporting of AIDS cases and individuals exhibiting evidence of prior exposure to the Human Immunodeficiency Virus (HIV) are in place; clarification of these statutes is now available from the Department for Health Services for physicians of Kentucky.
2. Testing for the AIDS virus should be mandatory for donors of blood and blood fractions, organs, tissues, ova or sperm, and, in accordance with Federal policy, immigrants to the United States, military personnel, and Federal and State prison inmates.
3. Through education and counseling, individuals at risk of exposure to the AIDS virus should be encouraged to undergo voluntary testing for the presence of evidence of HIV infection; these groups include homosexual males, intravenous drug users, hemophiliacs, and sexual partners of these indi-

viduals.

4. Testing and counseling services for individuals seeking this information must be made widely and readily available; in conjunction, complete confidentiality of counseling and test results must be ensured to remove the fear of discrimination that may prevent at-risk individuals from seeking counseling and testing.
5. Physicians throughout the state would be educated regarding counseling and testing, or referral of individuals seeking this information, in order that infected individuals may become aware of their infectivity and be counseled appropriately to prevent the spread of the disease.

Ardis D. Hoven, MD
Chairman

AIDS Policy Issues

Acquired Immunodeficiency Syndrome (AIDS) was first diagnosed in this country in 1981. It is caused by Human Immunodeficiency virus. The virus attacks the natural immune system of the body and makes it susceptible to any of a number of diseases which would be innocuous to normal persons. Associated with the body's lack of natural immunity is a series of diseases known as AIDS related complex.

The Centers for Disease Control (CDC), the epidemiologic arm of the United States Government, has tracked or monitored all reported cases of AIDS nationwide. There is no known cure for the disease and little effective treatment. The mortality rate for AIDS is predicted to be 100%, and incidence continues to increase.

Of all reported cases, the incidence of the disease is highest among homosexual or bisexual males, intravenous drug abusers, and their sexual partners. All data to date indicate that AIDS is not transmitted through casual contact but, rather, sexual contact, needlesharing, perinatally, and less often through transfusion of blood, or blood products, or needlestick injuries.

This document establishes policy on various AIDS issues strictly from epidemiologic and medical standpoints. No moral position is taken or suggested. Rather, the issue is treated on the basis of known medical facts and documented epidemiologic statistics. While fear of the disease is appropriate, methods to combat it as both a medical and social problem should not be taken through lack of knowledge.

Key factors which **must** be focused on are testing, transmission, and treatment. Testing per se does not prevent the spread of the disease. Treatment should be given based on known medical data. A harsh reality that must be confronted is the cost-effectiveness of testing, as well as treatment.

Statutory/Regulatory Factors

Sufficient laws and regulations are currently in effect to deal with AIDS, as with any other communicable and/or sexually transmitted disease. KRS 211.180 clearly gives this mandate to the Cabinet for Human Resources. KRS 214.010-185 establish requirements for reporting communicable diseases, the handling of blood specimens, and the diagnosis and treatment of venereal disease and other conditions. KRS 214.400, et seq, constitutes the "Sexually Transmitted Disease Confidentiality Act of 1986" passed by the General Assembly, and specifically mentions AIDS. The provisions of these sections include definitions, as well as penalties for not reporting.

902 KAR 2:010, et seq, deal with specific definitions and methods of control of communicable diseases and 902 KAR 2:080 deals specifically with sexually transmitted diseases. Several other sections deal with disease in specific settings, such as hospitals, skilled nursing facilities, family care homes, and others. Finally, the Department for Health Services has recently developed a clarification of the reporting law as it relates to HIV, which is as follows:

Clarification of Reporting Law as it Relates to HIV

1. Cases of acquired immunodeficiency syndrome (AIDS) are reportable by physicians and hospitals to their local health department or to the Department for Health Services within seven days of diagnosis (902 KAR 2:020). This regulation refers to cases that meet the definition of AIDS promulgated by the Centers for Disease Control. This definition is now in the process of being revised — the Department for Health Services will keep physicians informed of all changes as they occur.

   Since AIDS is defined as a sexually transmitted disease by 902 KAR 2:080, physicians and hospitals may substitute a reidentifiable code number for the patient's name and address on the reportable disease card. Since case reports must be screened for duplication at both the state and national level, reporting by name is strongly encouraged. If the patient's address is not reported, the county of residence must be reported. Please report all AIDS cases regardless of where they were first diagnosed. Prevalence as well as incidence is important for projecting medical care costs. Local health departments, the Department for Health Services, and the Centers for Disease Control take special care to maintain confidentiality.
2. Physicians and hospitals are not required to report other clinical manifestations of HIV infection at this time.
3. Because the HIV antibody test is a "serologic test which indicates the presence of infection with an organism associated with a reportable disease" (902 KAR 2:020), laboratories licensed in the state of Kentucky are required to report positive HIV antibody tests to their local health department or the Department for Health Services. A reidentifiable code number may be substituted for the patient's

name and address. This permits reporting of results from sites where testing is being conducted anonymously, so that statistics can be calculated; however, accuracy is limited by the inability to eliminate duplicate reports. Reports of positive HIV antibody tests are not sent to the Centers for Disease Control. Blood and plasma centers may report results in the form of statistical summaries rather than individually.

Identification Factors

Testing

Mandatory testing for the presence of HIV antibodies should be considered only in very rare circumstances. To reiterate, the disease is not transmitted through casual contact, and the statistical possibility of finding a seropositive person in any general population group is quite low. Voluntary testing for the presence of HIV has proven to be more effective when coupled with post-test counseling to seropositives on issues relating to the duration, manifestation, treatment, and likely outcome of the infection. Counseling of patients with positive testing results is one of the most effective ways to accomplish prevention. Except in rare circumstances, mandatory testing serves only to make individuals avoid being tested in order to escape the social and psychological stigma of the presence of the disease.

Currently, there are four testing sites operated by the Department for Health Services and plans are underway to provide testing services in family planning clinics, drug abuse centers, and mental health centers. Counseling — again, one of the most effective ways to accomplish prevention — should be targeted for expansion by means of increased State funding, Federal funding, and grant applications. An AIDS education effort should be primarily directed toward already identified high risk groups, and secondarily, other large homogeneous groups, such as large employee groups, schools, and so forth.

Statistical Effectiveness of Universal Testing

Blood Centers

The collection for further medical use of blood, blood products, body tissues and organs is appropriate. Simply, if the presence of the AIDS virus is detected, the blood or tissue can be diverted from human use. However, medical ethics demand that the individual from whom such specimens are acquired be notified confidentially and provided with voluntary counseling.

Employee Groups

The only justification for testing large employee groups is if a demonstrated reason could be shown as to why an institution must be entirely free of the virus. Such testing should be done in a nondiscriminatory manner, and testing specifically for HIV should be consistent with testing for all other diseases. In such circumstances, testing and concomitant medical costs should be borne by the employer. There should also be no discrimination by the insurance industry with regard to medical benefits coverage.

Hospital Setting

Mandatory testing of all hospital admissions is not appropriate. Adequate medical products already exist in all hospitals for appropriate precautions in handling body fluids. Realistically, testing every hospital admission would not be effective. The initial, or ELISA, test requires at least four hours of laboratory time to perform, which would result in a delay of eight to 24 hours before results were known. A positive ELISA test requires further substantiation by the Western blot test, which can only be accomplished in a small number of facilities, and the turnaround time for this test is approximately three weeks.

At an initial ELISA test cost of $10, $100,000 would be spent for every infected patient identified. Assuming that the needlestick rate in a hospital with 12,000 admissions per year is 30-40 per year, and assuming further that once a patient was known to be HIV positive, three-fourths of all needlesticks from that patient would not occur, $40 million would be expended for every infectious needle stick prevented. Because the risk of infection from a needlestick is only one in 200, $8 billion would be spent for every infection prevented. As mentioned previously, the patient's right to treatment in the hospital and informed consent regarding that treatment cannot be overlooked.

Premarital Testing

It is estimated that one in 10,000 persons tested in a premarital setting would test positive. This would cost $100,000 per identification. If a marriage license is denied on the basis of a blood test, the couple involved would likely seek a license elsewhere or cohabitate without a license. A more reasonable and effective step to take would be to make available voluntary counseling at the time of a marriage license application which might have some effect on preventing sexual transmission.

Food Handlers

As already mentioned, there is no evidence that the disease is transmitted through casual contact, or specifically, by food handlers. Again, such testing might indicate the presence of the infection, but it would have no effect on prevention.

Contact Tracing

Statutes and regulations already mentioned require the reporting of the presence of communicable diseases, primarily by medical personnel. Any contact tracing is necessarily voluntary, because there is no way to validate the information given. Information given voluntarily is likely to be accurate because of a concern for the welfare of sexual and drug abusing partners. The clarification of the reporting law already stated gives guidelines for physicians and others to make such reports, which are essentially of epidemiologic value only.

Isolation

Isolation of AIDS victims serves no purpose. Disease transmission does not occur through casual contact, and isolation would be prohibitive financially. Because it is predicted that patients are infectious for life, the State would be faced with the costs of isolation for the length of the patient's life.

Confidentiality

Current medical confidentiality laws are valid and effective. From the standpoint of day-to-day medical treatment at a facility, AIDS patient records could be identified by "biohazard" signs on the patient's door and medical chart without identifying a particular disease. These identifying indicators are routine in most facilities, and would maintain the confidentiality of the patient's status. Likewise, medical facility personnel should treat blood, blood products, body fluids, and body tissues using the same protocols already established for other so-called "biohazard" materials. Some form of labeling should be used to identify risk factors to laboratories when transferring human tissue and liquid products to laboratories from private physicians' offices.

AMA AIDS testing policy

The American Medical Association's policy on AIDS recommends:

Mandatory testing of:

- Donors of blood and blood fractions, organs, tissues, semen and ova.
- Inmates in federal, state prisons.
- Immigrants to the United States.
- Military personnel.

Routine voluntary testing with informed consent for the following types of individuals who are from areas with a high incidence of AIDS or who engage in high risk behavior:

- Patients at sexually transmitted disease clinics and drug abuse clinics.
- Pregnant women in the first trimester of pregnancy.
- People seeking family planning services.
- Patients who require surgical or other invasive procedures. (If the voluntary policy is not sufficiently accepted by such patients, the hospital and medical staff should consider implementing a mandatory program.)

As a matter of medical judgment, voluntary testing should be encouraged for:

- Individuals whose history or clinical status warrants this measure.
- Anyone who is homosexual, bisexual or has a history of intravenous drug use or who is the sexual partner of anyone in these groups.

What's new in Cancer Therapy

September 27-29
Hyatt Regency Lexington/Lexington Convention Center
Lexington, Kentucky

Scientific Sessions

The Hyatt Regency Lexington/Lexington Convention Center will host the 1988 Annual Meeting. The Scientific Program Committee has invited speakers from across the nation to participate in the sessions to be held during the mornings of September 27, 28 and 29. The program scheduled for Wednesday will feature William C. DeVries, MD, Humana Hospital Audubon; Russel Patterson, MD, Vice Chairman, Ethics & Judicial Council, AMA; and Andrew Malcolm, First Assistant National Editor, *New York Times*, speaking on, "The Ethics of Death and Dying." Following their presentations will be a question and answer session.

Specialty Groups

Programs for 21 specialty groups will be held during the afternoons of September 27, 28 and 29. No general sessions are scheduled during the specialty group meetings and all KMA members are invited. Scientific sessions and specialty group meetings will be held in the Hyatt Regency Lexington/Lexington Convention Center. By completing CME sign-up sheets at the beginning of each meeting, physicians attending general sessions and specialty group meetings will qualify for Category 1 Credit.

KMA House of Delegates

The opening meeting of the House of Delegates will be held Monday, September 26, at 9 AM in the Hyatt Regency Ballroom, located in the Hyatt Regency Lexington. Reference committee meetings will begin at 2 PM on Monday and the final meeting of the House will begin at 6 PM Wednesday, September 28. Officers for the 1988-89 Associational year will be elected during the final House meeting.

Other Activities

The 26th Annual KEMPAC Seminar will be held Monday evening, September 26, at the Hyatt Regency Lexington. A reception begins at 6 PM with dinner at 7 PM, and the program to follow at 8 PM. Susan Bryant, President of Research/Strategy/Management, Inc., based in Washington, DC, will be the featured speaker.

The President's Luncheon will be held September 28, with presentations of KMA awards and the installation of the 1988-89 KMA President, Bob M. DeWeese, MD. Featured speaker for the luncheon will be the Honorable Brereton C. Jones, Kentucky's Lieutenant Governor.

Scientific and Technical Exhibits will be on display featuring new medical products, services, and techniques. Members and guests have an opportunity to visit this area during the 30-minute intermissions scheduled throughout the general sessions and specialty group meetings.

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For more information about the Trust, call our professionals from Prudential-Bache Securities: John C. Schenkenfelder or Thomas O. Eifler at 502-561-5049 or 1-800-633-4248. Or, send in the coupon below.

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Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

BOARD ELIGIBLE INTERNIST — to join a busy two-physician practice in Lexington. Send curriculum vitae to PO Box 22734, Lexington, KY 40522-2734.

AMBULATORY MEDICINE CLINIC, LEXINGTON, KENTUCKY — Full-time positions available for FP/GP physicians. Competitive compensation, including paid malpractice insurance. No call hospital practice or business hassles. Resume: David A. Gammon, MD, PSC, 120 North Eagle Creek, Suite 360, Lexington, KY 40509.

INTERNIST — IMMEDIATE OPENING. Beautiful historic small college town in Central Kentucky. Must be BC/BE and proficient in coronary/intensive care management. Established practice with two other internists. Excellent salary and benefit package with full partnership after one year. Send CV to Physician Recruitment Coordinator, Berea Hospital, Estill Street, Berea, KY 40403.

FAMILY PRACTICE — IMMEDIATE OPENING. BC/BE to join 2 FPS in growing practice in a beautiful historic small college town in Central Kentucky. Excellent salary and benefit package. Send CV to Physician Recruitment Coordinator, Berea Hospital, Estill Street, Berea, KY 40403.

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FAMILY PRACTICE OPPORTUNITY — To join established solo practitioner. Guaranteed salary, health insurance, retirement benefits, educational and vacation time. Can eventually be full partner if desires, or share expenses and coverage, situation is very flexible depending on individuals wishes. Please reply to: Practice Opportunity, PO Box 1859, Corbin, KY 40701.

FAMILY PRACTITIONER — To join two other family physicians in a busy, downtown neighborhood practice. Full range of family medicine excluding obstetrics. Please contact: Pat Murphy, MD, 330 East Oak Street, Louisville, KY 40203, (502) 636-2833.

GENERAL INTERNIST, BC/BE — Lexington Clinic's Section of Internal Medicine is seeking a seventh internist. Competitive Salary, benefits and partnership is offered. Send CV to: William Wittman, MD, Lexington Clinic, 1221 South Broadway, Lexington, KY 40504.

WESTERN KENTUCKY — Seeking physicians for evening and weekend coverage in a low volume emergency department. Attractive schedule and compensation. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 31, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

8 PHYSICIANS WANTED — in South Louisville: 4 Family Practitioners, BE/BC Internist, Invasive Cardiologist, Gastroenterologist and Ophthalmologist. Great opportunity for young practitioners to join one of several different established practices or assume private practice of retiring physicians. Area offers modern hospital and office facilities with superior compensation and benefit packages. Serious inquiries only. Mail CV to Recruitment Manager, 5821 Pine Mountain Drive, #E, Louisville, KY 40214.

MEDICAL EDUCATION

June 16-18
The 33rd Annual Great Smoky Mountain Pediatric Seminar at the Park Vista Hotel, Gatlinburg, TN. Sponsored by University of Tennessee Medical Center at Knoxville, College of Medicine, Department of Pediatrics, and Knoxville Area Pediatric Society. Contact: Dr Sandra Loucks, University of Tennessee Medical Center, Dept of Pediatrics, 1924 Alcoa Hwy, Knoxville, TN 37920, (615) 544-9331.

September 3-5
Fourth Annual Multispecialty Oculoplastic Surgery Symposium, Lexington Marriott Resort, Lexington, KY. Contact: Jennifer DePrima Richard, Ophthalmology Center, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509, (606) 268-3754.

October 12-13
Care of the Seriously Ill Child — The 16th Annual Fall Pediatric Surgery/Pediatrics Symposium concerning "Acute Pediatric Emergencies," Lincoln Hotel and University Conference Center, Indianapolis, IN. Sponsored by the Indiana University School of Medicine. Contact: Jay L. Grosfeld, MD, (Symposium Director) Surgeon-in-Chief, Riley Hospital, 702 Barnhill Dr, Indianapolis, IN 46223, (317) 274-8353.

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Hospital Medical Staff Section
Eleventh Assembly Meeting
June 23-27, 1988

Medical Staffs from across the country are encouraged to elect a medical staff representative to participate in the AMA-HMSS Assembly meeting June 23-27, 1988, at the Marriott Hotel in Chicago.

The HMSS Assembly provides medical staffs with a unique opportunity to discuss and participate in the policymaking process of the AMA. In addition to the Assembly Meeting, the HMSS is sponsoring an educational forum on key issues of relevance to medical staffs. Topics include: tort reform, quality assurance, and Joint Commission results from its survey on governance and medical staff relationships. CME credits have been requested.

For further information about the AMA-HMSS, please call (312) 645-4754.

Notice of New Address

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Brief Summary. Consult the package insert for prescribing information.

Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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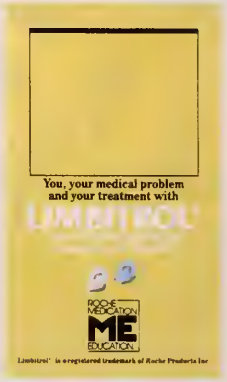
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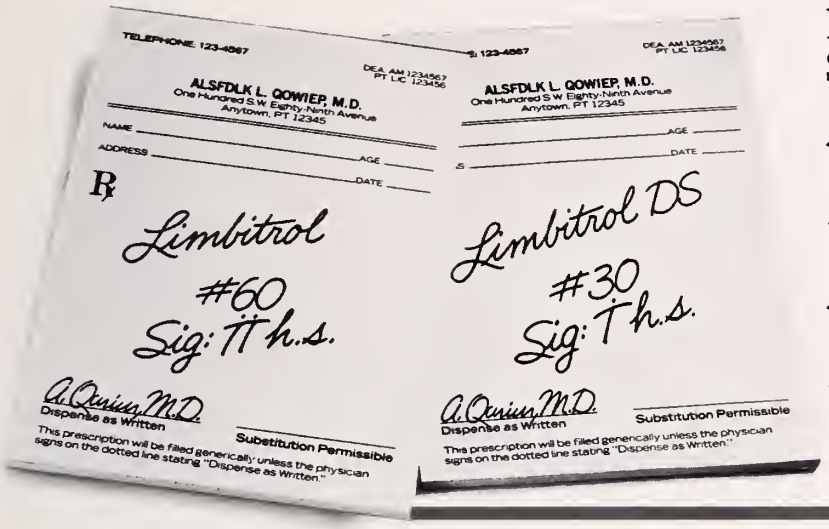
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- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

Limbitrol®Ⓥ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:
Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.
Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).
***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**
Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).
Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.
Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.
Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.
Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.
Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.
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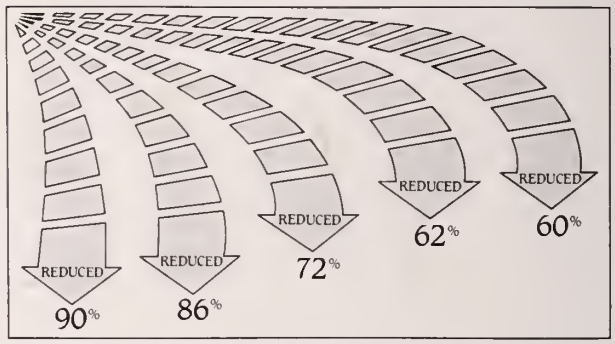
See Improvement In The First Week...[1]

And The Weeks That Follow

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week reduction in somatic symptoms[1]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

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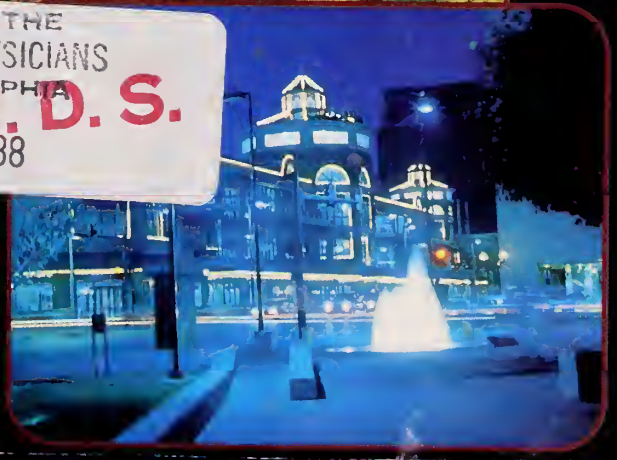








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TABLE OF

CONTENTS

STACKS

July 1988

Cover:
Attend **your** Annual Meeting in Lexington and take advantage of this growing city's many attractions: history, culture, traditions, educational facilities, shopping, entertainment and world famous horse farms, some of which are depicted in Linda Fortwengler's cover design.

SCIENTIFIC

Diagnostic Radiology in Fertile or Pregnant Women
Joseph G. Whelan, Jr, MD, FACR 353

Using a Questionnaire to Ascertain Hypertensive Patients' Knowledge
John P. Howard, MD; Julia A. Popham, MS 362

Hyperthyroid Crisis (Grand Rounds)
Donald E. Barker, MD; William E. Strodel, MD 371

EDITORIAL

Our Children 379

ASSOCIATION

KMA Board of Trustees Spring Meeting 384
Committees 386
Notice on Physician Advertising 387
Kentucky's Bluegrass Region Hosts Your 1988 KMA Annual Meeting 389

REGULAR FEATURES

President's Page 349
Auxiliary 381
Letters to the Editor 383
CME 390
Classified 382
Information for Authors 373

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VOL 86 NO. 7
JULY 1988

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July Buyer's Guide

CIBA Pharmaceuticals 351-352
Charleston Area Medical Center 375
Classified 382
Differential Advantage, Ltd. 374
Humana Hospitals 390
KMA Insurance Agency, Inc. 348, 368
KMIC 376
KMIC Leasing Company 344
Lakeshore Systems 370
Eli Lilly & Company 378
Medical Protective Company 369
Methodist Evangelical Hospital 374
PIE Mutual Insurance Company 380
Roche Laboratories 391-392
U.S. Air Force 370
U.S. Army Reserve 350, 377



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RB-RVS



Many of you have heard these initials but probably a lot of you haven't. In the next two years, I'll guarantee you will all know what they mean. These initials stand for Resource-Based Relative Value Scale. With the escalation of health care costs, Congress mandated HCFA to propose a plan and report back to them. HCFA contracted with Harvard to produce this study.

This study was started in January 1986, with twelve specialties represented. Six more were added six months later. Three hundred and forty services in 18 different specialties have been cross-referenced between specialties. This would cover over 50% of Medicare coded services and, with extrapolation, it will cover over 80%. Since the original mandate, Congress has added another 12 or so specialties which HCFA will fund, and further studies will proceed.

The formula RV^S = Total work (time × intensity) × training cost × practice cost is the basis of this new proposal. It takes into consideration cognitive services for the first time. This report is to be reported to HCFA on July 14, 1988. Thirty days later, it is to be given to the physician's payment review commission and, at this time, the report will be public for the first time.

Everyone is in agreement that there will be a change in the present UCR payment systems. The AMA's only role in this study is strictly advisory, to assure that the study is accurate and fair. Their only commitment is to see the project finished. The AMA is firmly committed to the concept of balanced billing and to equitable (not equal) reimbursement for all physicians.

It should be stressed that this is just a research tool and should not be judged until the results are out. It will not be perfect, and it will certainly not please everyone. It may not please anyone. Even if Congress accepts this proposal (and this is questionable), it would not be implemented until January 1, 1990, which allows plenty of time to study the findings and reach a rational conclusion.

You must remember, however, Congress is totally committed to three principles:

1. Predictability
2. Volume Control
3. Beneficiary Protection (actually re-election protection)

Even if the RB-RVS is acceptable to medicine, it may be difficult for Congress to accept over a regional capitation system which would better fit their three principles.

These next two years will be extremely trying times for the profession, but medicine must remain unified and not splintered in order to have strength in negotiating the best possible solution for all of medicine. It is absolutely essential, regardless of the ultimate solution, that organized medicine assures that there will be no serious detrimental effect on the amount and quality of physician services to the nation's elderly.

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†Pooled mean serum potassium following oral administration of 30 mEq K-Tab compared to 24 mEq Slow-K in diuretic-treated hypertensives (n = 20) over 8 weeks.

C I B A

References: 1. Data on file, CIBA Pharmaceutical Company. **2.** Skoutakis VA, Acchiardo SR, Wojciechowski NJ, et al: Liquid and solid potassium chloride: Bioavailability and safety. *Pharmacotherapy* 1980;4(6):392-397. **3.** Skoutakis VA, Carter CA, Acchiardo SR: Therapeutic assessment of Slow-K and K-Tab potassium chloride formulations in hypertensive patients treated with thiazide diuretics. *Drug Intell Clin Pharm* 1987;21:436-440.

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1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis; in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.
2. For prevention of potassium depletion when the dietary intake of potassium is inadequate in the following conditions: patients receiving digitalis and diuretics for congestive heart failure; hepatic cirrhosis with ascites; states of aldosterone excess with normal renal function; potassium-losing nephropathy; and certain diarrheal states.
3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS
Potassium supplements are contraindicated in patients with hyperkalemia, since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene) (see **OVERDOSAGE**).

All solid dosage forms of potassium supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation. Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to an enlarged left atrium.

WARNINGS
Hyperkalemia (See OVERDOSAGE).
In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic.

The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction With Potassium-Sparing Diuretics
Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene), since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions
Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage, or perforation. Slow-K is a wax-matrix tablet formulated to provide a controlled rate of release of potassium chloride and thus to minimize the possibility of a high local concentration of potassium ion near the bowel wall. While the reported frequency of small-bowel lesions is much less with wax-matrix tablets (less than one per 100,000 patient-years) than with enteric-coated potassium chloride tablets (140-50 per 100,000 patient-years) cases associated with wax-matrix tablets have been reported both in foreign countries and in the United States. In addition, perhaps because the wax-matrix preparations are not enteric-coated and release potassium in the stomach, there have been reports of upper gastrointestinal bleeding associated with these products. The total number of gastrointestinal lesions remains approximately one per 100,000 patient-years. Slow-K should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis
Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, or potassium acetate.

PRECAUTIONS
General:
The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis *per se* can produce hypokalemia in the absence of a deficit in total body potassium, while acute acidosis *per se* can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium.

Information for Patients
Physicians should consider reminding the patient of the following:
To take each dose without crushing, chewing, or sucking the tablets.
To take this medicine only as directed. This is especially important if the patient is also taking both diuretics and digitalis preparations.
To check with the physician if there is trouble swallowing tablets or if the tablets seem to stick in the throat.
To check with the doctor at once if tarry stools or other evidence of gastrointestinal bleeding is noticed.

Laboratory Tests
Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions
Potassium-sparing diuretics: see WARNINGS.

Carcinogenesis, Mutagenesis, Impairment of Fertility
Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C
Animal reproduction studies have not been conducted with Slow-K. It is also not known whether Slow-K can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Slow-K should be given to a pregnant woman only if clearly needed.

Nursing Mothers
The normal potassium ion content of human milk is about 13 mEq/L. It is not known if Slow-K has an effect on this content. Caution should be exercised when Slow-K is administered to a nursing woman.

Pediatric Use
Safety and effectiveness in children have not been established.

ADVERSE REACTIONS
One of the most severe adverse effects is hyperkalemia (see CONTRAINDICATIONS, WARNINGS, and OVERDOSAGE). There also have been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see CONTRAINDICATIONS and WARNINGS); other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE
The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see CONTRAINDICATIONS and WARNINGS). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration (6.5-8.0 mEq/L) and characteristic electrocardiographic changes (peaking of T waves, loss of P wave, depression of S-T segment, and prolongation of the Q-T interval). Late manifestations include muscle paralysis and cardiovascular collapse from cardiac arrest (9-12 mEq/L).

Treatment measures for hyperkalemia include the following: (1) elimination of foods and medications containing potassium and of potassium-sparing diuretics, (2) intravenous administration of 300-500 ml/hr of 10% dextrose solution containing 10-20 units of insulin per 1,000 ml, (3) correction of acidosis, if present, with intravenous sodium bicarbonate; (4) use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

DOSAGE AND ADMINISTRATION
The usual dietary intake of potassium by the average adult is 40-80 mEq per day. Potassium depletion sufficient to cause hypokalemia usually requires the loss of 200 or more mEq of potassium from the total body store. Dosage must be adjusted to the individual needs of each patient but is typically in the range of 20 mEq per day for the prevention of hypokalemia to 40-100 mEq or more per day for the treatment of potassium depletion. Large numbers of tablets should be given in divided doses.

Note: Slow-K slow-release tablets must be swallowed whole and never crushed, chewed, or sucked.

HOW SUPPLIED
Tablets — 600 mg of potassium chloride (equivalent to 8 mEq) round, buff colored, sugar-coated (imprinted Slow-K)
Bottles of 100 — NDC 0083-0165-30
Bottles of 1000 — NDC 0083-0165-40
Consumer Pack — One Unit
12 Bottles — 100 tablets each — NDC 0083-0165-65
Accu-Pak®: Unit Dose (Blister pack)
Box of 100 (strips of 10) — NDC 0083-0165-32
Do not store above 86°F (30°C). Protect from moisture. Protect from light.

Dispense in tight, light-resistant container (USP).

Dist. by:
CIBA Pharmaceutical Company
Division of CIBA-GEIGY Corporation
Summit, New Jersey 07901

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C I B A

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Diagnostic Radiology in Fertile or Pregnant Women

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Diagnostic x-rays may be ordered and taken at any time during the menstrual cycle and at any stage of pregnancy including films over the pelvis where these x-rays are related to the current illness. No responsible radiation protection agency or medical authority has recommended avoidance of properly justified x-rays on the basis of radiation risk. In properly justified radiological procedures related to the current illness, pregnancy need not be determined prior to these studies. The patient should be questioned as to the possibility of pregnancy. The referring physician, in consultation with the radiologist, should indicate on the patient's record any such discussion with the patient regarding the benefit/risk of the examination and the reasons for the decisions to proceed, modify, or postpone the examination. If an x-ray examination is performed before patient's pregnancy is discovered, there is normally little cause for concern. Radiation exposure is so small that the risk of interference with fetal development is negligible. Interruption of pregnancy is rarely justified because of radiation risk to the embryo-fetus from diagnostic x-ray examinations. This includes exposure from both abdominal and peripheral examinations.

Physicians frequently encounter women of childbearing age who present with symptoms of a medical illness requiring a diagnostic radiologic evaluation. On occasion, some of these patients may subsequently be found to be pregnant, after the examination. Most physicians are not familiar with the current policies of scheduling of diagnostic x-rays, with the benefit/risk of diagnostic x-rays in these women, and they are even less familiar with the advice to give these women found to be pregnant following radiation exposure.

The purpose of this paper is to address some of these issues, particularly the policies of the American College of Radiology (ACR), of the American College of Obstetricians and Gynecologists (ACOG), and of some of the radiation protection agencies. The radiation doses and risks, the benefit/risk of the radiologic examinations, consideration of abortion following exposure to diagnostic x-rays, and informed consent will also be discussed.

Scheduling of Diagnostic X-Rays in Relation to the Menstrual Cycle, Potential Pregnancy, or Actual Pregnancy

In the United States, only a few hospitals have adopted any formal scheduling procedure for x-ray examination of the lower abdomen with regard to the phase of the menstrual cycle. This is due in part to the very low frequency of truly elective examinations that are postponable, and in part to many practical problems in implementing such a policy. Non-elective studies which do contribute to the diagnosis or treatment of current disease should be performed in fertile women without regard to the stage of menstrual cycle. A non-elective radiological procedure would include any procedure necessary to assist in evaluating a new symptom or sign. The presence of pain, bleeding, change in bowel or urine habits, or other unusual symptoms and signs related to the pelvis or abdominal cavity should be evaluated as soon as possible. Delay in arriving at the diagnosis may be detrimental to the patient's health. If in the judgement of the attending physician, protection of the patient's health requires a radiological examination to be carried out at a specific time, and if the examination is carried out with adequate equipment and careful technique, then the potential benefit to the health of the patient and/or the embryo-fetus will, in most cases, outweigh the potential deleterious effect of the irradiation. The hazards to the fetus below ten rad dose are conjectural and therefore the physician must weigh the possible hazards (which do not include malformations or gross retardation) against the real hazard of compromising the patient's health by delaying the diagnosis.[1,2,3]

The ACR has addressed the policy of diagnostic x-rays during known pregnancy. The most probable effect from radiation exposure during the first two weeks of pregnancy is resorption of the preimplanted stage of the embryo. This will result in only a slight addition (approximately 11 cases) to the spontaneous abortion rate which is estimated to be 3.75 million spontaneous abortions per year. Delaying an examination during this period will only confront the physician with a decision, once a pregnancy is established, to conduct the examination during major organogenesis, delay until fetal stages, until after birth, or eliminate the exam entirely. If an examination would not be performed, knowing a woman is pregnant, it is probably an unnecessary exam. If an examination of the lower abdomen or pelvis

would be conducted, knowing the woman is pregnant, then no delay is indicated. The least objectionable period for conducting such an examination may be the 14th to 28th day following the last menstrual period.[2]

There are also special considerations for radiation workers who are pregnant. During the entire gestation period, the maximum permissible dose equivalent to the embryo-fetus from occupational exposure of the expectant mother should be 0.5 rem.[4] From studies performed, the estimated conceptus (fetal) dose would be in the range of 18 to 200 mrads. It would be highly unlikely that any one area of diagnostic x-radiation would exceed the limits of 500 mrads during the entire gestational period.[5] Radiation workers should be monitored during their routine work load of radiation exposure.

Three major policies regarding scheduling of diagnostic x-rays are:

I. NCRP REPORT #54 1979[1]

For women of childbearing capacity, the physician requesting a radiological or nuclear medicine examination involving the lower abdominal pelvic region should ascertain whether the patient is, or could be, pregnant.

The final decision to proceed or not to proceed with the examination must depend on considerations of the patient's health, and on her wishes, and reside with the attending physician in consultation with the radiological expert when such services are utilized; i.e., the attending physician must retain full discretion to decide each case according to his judgement.

II. ACOG Guidelines, May 1977[6]

a. **The use of x-ray examinations should be considered on an individual basis. Concern over harmful effects should not prevent the proper use of radiation exposure when significant diagnostic information can be obtained. Pre-examination consultation with the radiologists may be useful in obtaining optimal information from the x-ray exposure.**

b. **There is no measurable advantage to scheduling diagnostic x-ray examinations at any particular time during a normal menstrual cycle.**

c. **The degree of risk involved in the x-ray examination if the person is pregnant, or should become pregnant, should be explained to the patient and documented in her record.**

III. ACR Policy, 1977[7]

Official Council Action

Abdominal radiological examinations that have been requested after full consideration of the clinical status of the patient including the possibility of pregnancy need not be postponed or selectively scheduled, except in those few instances where the examination may not be related to the patient's current illness.

Determination of Pregnancy

The following are several examples where diagnostic x-rays are obtained in the presence of known or potential pregnancy. The first is a patient obviously pregnant who has been in an automobile accident and is suspected of having a fractured hip or pelvis. The second is a patient who is in active labor with possible cephalopelvic disproportion. Pelvimetry is obtained in order to determine the method of delivery. And thirdly, another patient who appears obviously to be pregnant and presents with massive lower GI hemorrhage and a negative colonoscopy. A colon study is required to determine the area of bleeding. It is obvious from these examples that the radiographic studies would be of utmost importance rather than first determining pregnancy. Reynold F. Brown, MD, a radiologist, a radiation physicist, and a spokesman for the ACR, discussed the need for a pregnancy test. The radiological examination criteria for potentially pregnant women should be the same as for those of known pregnancy. If the examination is indicated there is no need to determine pregnancy because it would not affect the decision to proceed. If the exam would not be performed because of pregnancy the study may be in doubt and consultation with the radiologist might be useful to examine the options available for the patient's best interest.[8] Only medical judgement can determine what exams should be performed in the proper order. This cannot be regulated.

Radiation Dose to the Patient and Embryo-Fetus from Diagnostic X-Rays

Figure 1 illustrates some factors used in a determination of radiation absorbed dose from diagnostic x-rays. The Roentgen (R), a quantity of radiation, represents the ability of the x-rays to ionize air. The amount of radiation absorbed dose in tissue is quantitated in rads and is,

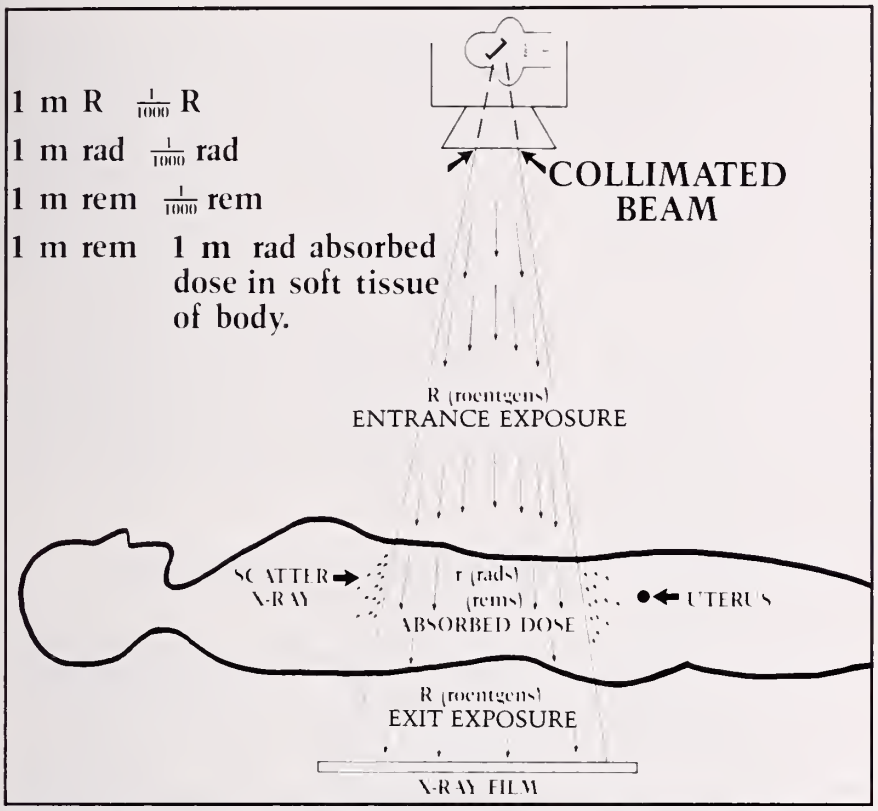


Fig 1 Collimated x-ray beam with radiation exposure terms used in diagnostic radiology

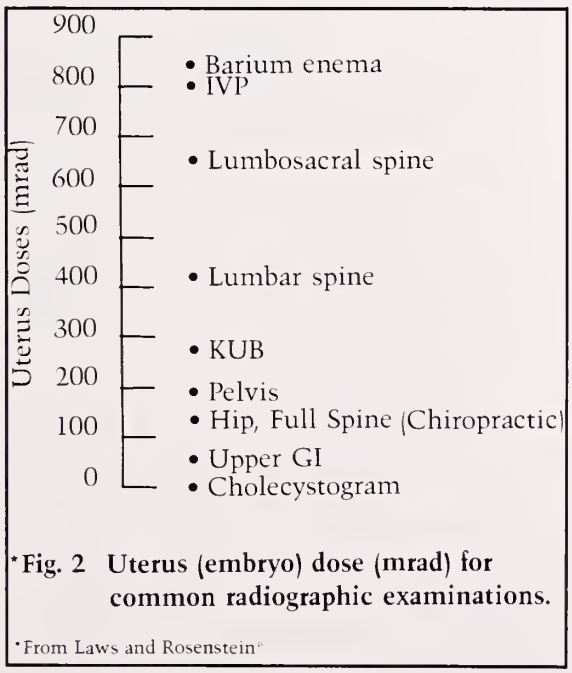


***Fig. 2 Uterus (embryo) dose (mrad) for common radiographic examinations.**

*From Laws and Rosenstein[10]

numerically, nearly equal to the amount of exposure which is measured in Roentgens. Radiation Absorbed Dose, rads, is actually an amount of energy absorbed from the radiation beam by one gram of tissue. The term rem is another expression of absorption of radiation and it is based on the response of a specific tissue to a given type of radiation. In this paper for soft tissues the rem is equivalent to the rad. There are much more detailed calculations and equivalents beyond the scope of this paper.[9]

Table 1 lists the various types of examinations in diagnostic radiology and then gives the approximate dose to the ovaries and the embryo.[2] Fig 2 estimates the amount of radiation the uterus (embryo) receives from various common x-ray examinations.[10] Most common x-ray examinations are less than one rad per examination. In practice very rarely does a diagnostic examination, including fluoroscopy, result in a dose to the uterus as high as five rads (5000 mrads).[1] Radiation doses to the ovaries and embryo may vary depending upon the type of equipment used, the film-screen combinations, use of various filters and grids, collimation, radi-

TABLE 1
OVARIAN AND EMBRYO DOSES FROM DIAGNOSTIC RADIOLOGY*

(Doses in mrad)

Examination	Images (Number)	Ovaries	Embryo
Chest	1.5	0.06	0.06
Skull	4.1	+	+
Cervical spine	3.7	+	+
Ribs	3.0	4	0.5
Shoulder	1.8	+	+
Thoracic spine	2.1	1	0.1
Cholecystogram	3.2	6	5
Lumbar spine	2.9	400	410
Upper GI	4.3	45	50
KUB	1.7	210	260
Barium enema	4.0	790	820
Lumbosacral spine	3.4	640	640
IVP	5.5	640	820
Pelvis	1.3	150	200
Hip	2.0	80	130
Mammography	2.0	‡	‡
Urethrocystogram		1500	
Hysterosalpingogram		5900	
Paranasal sinuses		1	
Carotid angiogram		10	
Dental	1.0	0.01	
CT brain	5.0	7	
CT abdomen	5.0	40	

*Modified from table 10, ACR, 1985[2]
+Less than 0.01 mrad.
‡Considered negligible compared to dose to breast.

ation source-film distance, number of films used for the exam, and the developing techniques. The radiation dose to an embryo was calculated in a patient who had received gallbladder x-rays, upper GI studies, small bowel studies, and a colon examination. The patient had a total of 34 x-ray films taken and in all of these examinations the fetus received approximately 1.369 rads. This emphasizes the small amount of radiation that the fetus receives from multiple examinations including x-rays of the pelvis.[11]

When there is a reasonable possibility that a patient may be pregnant and the embryo-fetus may be exposed to the primary beam, consideration should be given to modifying the examination to reduce the radiation dose to the embryo-fetus if the diagnostic value of the study is not compromised. Most examinations however have been carefully designed to obtain the maximum information with the minimum amount of radiation exposure. There are several ways of reducing radiation to the fetus during the examination. Use of a PA (posterior anterior) projection with the urinary bladder partially filled may be considered. The uterus is slightly more anterior in this position.[12] The spine will also absorb considerably more radiation than the soft tissues, which will reduce the amount of x-ray to the fetus. Collimation of the x-ray beam is also of utmost importance in reducing the amount of radiation to the patient and to the fetus particularly if the area is not of particular interest during a radiographic examination. When the primary diagnostic beam margin is 5 cm or more from the fetus there is a negligibly small amount of scattered radiation reaching the fetus. Exposures of the primary beam more than 10 cm from the fetal area are considered non-contributory to the fetal dose. (See Fig 1). This is based on a study from the DHEW where scattered radiation was measured in phantoms.[13] Peripheral examinations that are remote from the uterine (fetal) area such as extremities, head and neck exams, chest x-rays, and upper abdomen films, can therefore be safely performed, without any significant radiation exposure to the fetus.

Radiation Risks to the Embryo/Fetus from Diagnostic X-Rays

The ACR has extensively reviewed and summarized the literature regarding radiation risks to the fetus from low level radiation.[2] Table 2 lists the major risks and the critical times of radiation exposure to the fetus. Any examination during which the fetus is outside the primary beam can be performed without measurable risk of radiation injury to the embryo. The only examinations that carry meaningful risks to the

TABLE 2

MAJOR RADIATION EFFECTS

ON THE EMBRYO AND FETUS*

Effect	Period of Maximum Sensitivity	Days Post Conception†	Estimated Minimal Effective Dose (rem)
Prenatal death	Preimplantation	0-9	10
Malformation	Organogenesis	15-50	10
Growth retardation	First trimester	15-90	10
Mental retardation	First trimester	15-90	10
Childhood cancer	First trimester	15-90	Unknown

* Modified from table 7; ACR, 1985[2]

† Human

embryo are those involving the lower abdomen and pelvis.

Stewart et al reported a large scale retrospective epidemiological study in England demonstrating a significant association between in utero exposure to diagnostic x-rays and leukemia.[14] Oppenheim et al however found no increased incidence of cancer of offspring in healthy females who had elective pelvimetry.[15] The possibility remains that the association of leukemia and diagnostic x-rays is at least in part caused by factors other than radiation, and may be the result of biasing factors introduced by selections of subjects irradiated as a consequence of medical indications.[3,4] The risk of cancer for the embryo/fetus is estimated to be between one in 1,000 to one in 10,000 chances per rad for the first ten years of life.[1,8] In no case is there data valid for doses of less than 10 rem.[2,16]

Four percent to 6% of all babies are born with varying degrees of congenital defects regardless of radiation history.[1,3,4] Prenatal death and congenital abnormalities related to radiation appear to be a threshold phenomenon and most authors have suggested at least 10 rem.[2] The first trimester is the most sensitive for exposure. Radiation doses below the 10 rad level received at any stage of pregnancy according to the best knowledge available today is very small when compared to the normal risk.[1,3] During major organogenesis starting two until ten weeks post conception, for doses of less than 5 rad received at the period critical for the induction of any one specific type of malformation, it is unlikely that an increase in this type of malformation could be measurable in human populations.[1] The risk of malformations is significantly increased above controls at doses above 15 rads.[1] Others feel major congenital malformations are highly unlikely to occur in the human for doses of less than 25 rads absorbed from the 14th day of human pregnancy until term.[3] Major malformations include absence or gross distortion of the tissue, organ, or tissue component, or identification of easily absorbable tissue hypoplasia such as microcephaly, microphalmia, testicular atrophy, or cerebral hypoplasia.[3] Head circumference reduction was most significant in children who were believed to have received doses greater than 50 rads. The head size of some children irradiated in utero at Hiroshima and Nagasaki diminished even in doses of 10 to 20 rad range which included neutron radiation although the mentality of this low dosage group was normal. It is possible that other environmental factors contributed to the increased numbers of small head sizes.[3] There was an increase in prevalence of mentally retarded children with maternal doses of 50 rad or more at Hiroshima and only at high doses of 300 rads or more at Nagasaki.[4] Mental retardation sensitivity is related to timing of exposure usually between the 8th and 15th weeks of pregnancy.[2] Minimal malformations have been described for doses as low as 5 rem.[17] The actual number of congenital malformations from diagnostic x-rays may be one in 2,000 or even one in 10,000 depending upon the specific situation.[8]

Doctor Allen Brodsky, Health Physicist from the Nuclear Regulatory Commission (NRC), described the extremely small risk from x-rays.[18] Fig 3 illustrates his description of the extreme odds of cancer/death from a given radiation exposure. There is considerable evidence suggesting that cancer and perhaps many genetic effects cannot develop unless two or more chemical changes occur in nearby gene sites, often in the proper order. Gamma rays are always emitted in discrete packets of energy, like bullets. Imagine these bullets being aimed by a nervous rifleman with two small targets several hundred yards away. One of the targets is a golf ball hanging from a tree by a flexible rubber band. The other target is a baseball hanging by an inflexible string. The baseball is hanging behind the golf ball blocking a hole in the tree. In order to give the tree cancer the golf ball must be knocked into the hole in the trunk of the tree where it will stick and stay once it gets in. However the baseball is blocking the hole. Thus the first hit must break the string holding the baseball. Otherwise even if the golf ball is hit and heads toward the hole, it will hit the baseball, deflect in some direction, and eventually swing back to rest in the same equilibrium position. This indicates biological repair. Thus, two hits must occur and in the proper order. It would be a very unlucky tree that could be hit twice in the right order and get cancer, unless the number of bullets aimed began to reach some enormous number. Even so, for two or more bullets one can easily see that the chances of tree cancer are not zero, and increase with increasing exposure to bullets. The statistical nature of radiation effects in humans at low dose levels is similar to the bullet — golf ball — baseball analogy just described. The probability that a single gamma photon (or a small number) will cause a biological, unrepairable and medically important effect is extremely small. It is a rare event involving

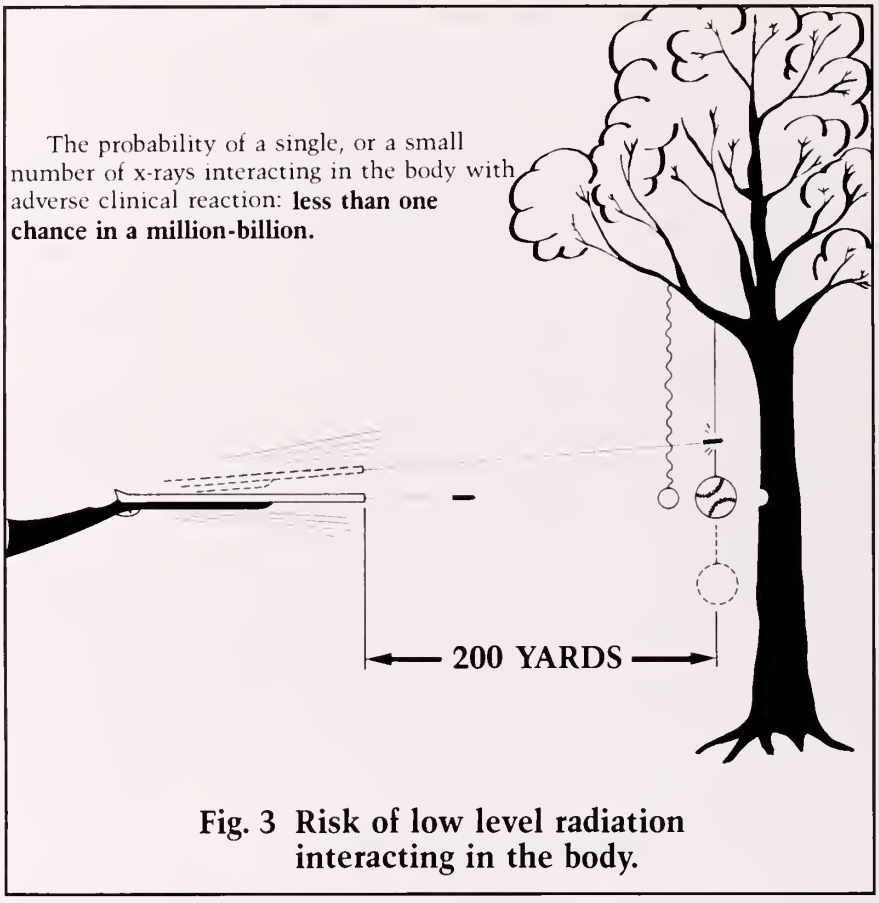


Fig. 3 Risk of low level radiation interacting in the body.

extremely small and/or extremely rare targets. The probability of a single photon entering the body interacting in a clinically important way is less than one in a million-billion.

Benefit/Risks

Most patients think only of the risks of diagnostic x-ray without considering the benefits and necessity of the exam. In 20 years of radiology practice, I have detected and followed the progress of life threatening diseases almost daily such as ulcers, inflammatory conditions, vascular disease, and cancer. It is estimated that 145,000 cancers of the colon and rectum will develop in the United States in 1987, 2,400 of these in Kentucky in which 40% will die from their disease.[19] Also 130,000 breast carcinomas will develop; 1,900 of these will occur in Kentucky. Thirty-two percent of these women will die from their disease. During mammography screening in the 60s there was a one-third reduction in mortality strictly related to the impact of early detection by mammography.[19] During the second breast screening program in the 70s, 57% of breast lesions were detected by mammography alone.[19] These statistics demonstrate the fact that lives can be saved with the use of diagnostic x-rays. The entire May/June and July/August 1987 issues of the *CA — A Cancer Journal for Clinicians* are devoted to imaging in cancer patients, which emphasizes the use of imaging modalities in the detection and staging of various cancers.[20,21] As I wrote this article my associate found a malignant lesion in the colon of a 29-year-old female. From my personal standpoint, my sister, age 34, had epigastric pain and slight anemia. Upper GI and gallbladder series were normal. After waiting three months she obtained a colon exam at which time a malignancy of the hepatic flexure with extensive metastasis was found. She expired in six months. Perhaps earlier detection of this lesion could have saved her life.

The National Academy of Sciences Committee has reduced by one-half its 1972 estimates of human cancer risks for low level ionizing radiation.[16] These estimates of cancer risks are in the very low level radiation exposure where no human epidemiological data are available. Doctor Jacob I. Fabrikant, one of the 23 members of the Committee indicated that the risk/benefit relationship from the BEIR III Committee Report has improved on the benefit side.[22]

Use of diagnostic x-rays has improved and is much safer today. Radiation has been reduced with the use of image amplifiers, digital computers, and pulsed x-ray beams. Use of faster film-screen combinations, which are rated somewhat similarly to photographic film, has reduced radiation exposures by one-fourth or more. The quality and safety of diagnostic x-rays has also improved by national and state surveillance programs. In the late 70s, the NEXT (National Evaluation of X-ray Trends) program was conducted.[23] The radiation output of individual machines was measured and the results were compared to national averages and these were supplied to the users. In Kentucky all x-ray tubes must be licensed, the operators must be certified, and the facilities are periodically surveyed for compliance.[24,25,26]

Therapeutic Abortion Following Diagnostic X-Rays

In years past the "Danish Rule" (or Hammer-Jacobsen Rule) served as a guideline for clinical use in which abortion was advised if the

fetal dose was thought to be 10 rads or greater but was not recommended if less than 1 rad. The radiation limits suggested for abortion were not sharply defined and should be open for individualization.[27] It is very unlikely that one or more diagnostic x-ray examinations could result in a dose to the fetus within a short period of time of more than 5 rads. When the fetus receives more than 5 rads, the dose usually arises from a series of examinations spread over a number of days. The effect of a series of doses delivered over several days is much less than a single dose equal to the sum of the individual doses. It is extremely unlikely therefore that a situation would ever arise justifying recommendation of a therapeutic abortion because of radiation risks to the embryo from diagnostic x-ray examinations.[2] In very unusual circumstances when it is suspected that a diagnostic procedure or combination of procedures may have resulted in an uncommonly large exposure, effort should be made to determine the fetal dose and an expert should be consulted about the possible hazards.[28] The patient makes the ultimate decision with the advice of the attending physician and the consultant regarding a therapeutic abortion.[1]

Radiation exposure alone should not be used as a justification for interruption of pregnancy. RL Brent states "a decision as to whether to terminate the pregnancy will depend upon: (a) hazard of the pregnancy to the expectant mother; (b) the extent and type of radiation hazard to the embryo or fetus; (c) the ethnic and religious background of the family; (d) the laws of the state pertaining to legal abortion; (e) any other relevant considerations."[1,3] In response to the question posed to Robert O. Gorson, MS, "Are there any indications for a therapeutic abortion connected with diagnostic abdominal or pelvic x-ray exposures of a newly pregnant woman?" Dr. Gorson stated "theoretically, yes — but for all practical purposes, no. If, between the 12th and 40th day of pregnancy, the embryo were to receive a dose of 25 rads or greater within a very short period, (minutes to a few hours), the risk of radiation-induced malformations may be sufficient to consider discussing therapeutic abortion with the attending physician."[2]

The official council policy of the ACR (1977) is:[7]

> **Interruption is rarely justified because of radiation risks to the embryo-fetus from diagnostic x-ray examinations. This includes exposure from both abdominal and peripheral examinations.**

Informed Consent

For women of childbearing capability, the physician requesting a radiological or nuclear medicine examination involving the lower abdominal pelvic region should ascertain whether the patient is, or could be, pregnant. The final decision to proceed or not to proceed with the examination must depend on considerations of the patient's health and on her wishes and reside with the attending physician in consultation with the radiological expert when such services are utilized, ie, the attending physician must retain full discretion to decide each case according to his judgement. The radiologist should also be advised as to the possibility of pregnancy. Even though in most cases the examination could be carried out in spite of possible pregnancy, the radiologist should discuss the question with the patient and indicate on the patient's record any such discussion with the patient or referring physician and the reasons for the decision to proceed, modify, or postpone the examination.[1,2]

Since no valid data exists for doses less than 10 rem, informed consent regarding risks is extremely difficult and rarely necessary in diagnostic radiology. According to the policy of the ACR, in the performance of radiologic procedures carrying a relatively low risk and usually done at the request of the attending physician who is familiar with the clinical problems of the patient, it is not necessary, and at times may be unwise, to discuss with the patient the remote possibility of complications of the procedure. The radiologist should use his best judgement regarding consultation with the physician concerning the indication for the procedure and management of examination.[29] Most patients fear radiation at any level and it is difficult to discuss differences in radiation levels. Some publications have attempted to correlate the risks of common x-ray examinations with human health and cancer.[30] However, several authorities have refuted this work indicating that the theoretical estimates are based upon the authors' own dubious arithmetic.[31,32] The ACR considers diagnostic x-ray safe but not completely risk free.[2] If there is a risk from medical radiation it is extremely small numerically. Current data suggests the risk to an average patient from a common diagnostic x-ray procedure is about the same as traveling 300 miles by automobile, working ten days in a typical blue-collar occupation, or drinking a bottle of wine. Risk estimates cannot be directly applied to individual patients.

In addition to Doctor Brodsky's description of the extremely small risk from x-rays, I will quite often compare x-ray exposures to background radiation to which we are all exposed, in some areas as much as ten times higher than others. In Kentucky one receives an average of 46 mrem per year, while living in Colorado one receives as much as 90 mrem per year due to elevation.[33] In Espirito Santos, Brazil, the inhabitants receive 1.2 rads (1,200 mrads) each year of life. Yet there has been no evidence of detectable effects on congenital anomalies, pregnancy termination, stillbirths, or postinfant mortality in children from this background radiation.[34] Also a person taking a five-hour plane flight at 40,000 feet will receive 2.5 mrad background radiation.[35] Radiation exposure to the fetus from a routine gallbladder x-ray (5 mrad) would be equivalent to a 10-hour plane flight at 40,000 feet. I find it interesting that no one at the airport inquires as to the possibility of pregnancy nor do they suggest a pregnancy test prior to some of these prolonged plane flights. Also there is no explaining any potential risks including background radiation or accidents from plane flights. Medical radiation is given in a shorter period of time of several hours to several days, but this is in fact also fractionated, and not given as a single dose.

When therapeutic abortion is considered, exposure to the embryo-fetus from diagnostic procedures would very rarely be cause by itself for termination of pregnancy.[1] There should be at least 25 rads or more fetal exposure over a short period of time, and many factors other than just radiation play a role in the decision.[2,3] Reynold F. Brown pointed out that one would destroy at least 999 normal fetuses in order to terminate one potential abnormal fetus from radiation. This should be compared to the birth rate deformity of 4% to 6% without radiation exposure.[8]

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Health and Safety Tip From the American Medical Association

MARKERS LISTED TO IDENTIFY ALCOHOLICS

How can you tell that a regular, heavy drinker has crossed over the line and become an alcoholic, who no longer can control his or her drinking?

The American Medical Association in its Manual on Alcoholism points to some markers to help identify the alcoholic.

1. Increasing consumption of alcohol, with frequent, perhaps unintended, episodes of intoxication.

2. Drinking to handle problems or relieve symptoms.

3. Obvious preoccupation with alcohol and the frequent need to have a drink.

4. Surreptitious drinking or gulping of drinks.

5. Tendency toward making alibis and weak excuses for drinking.

6. Refusal to concede what is obviously excessive consumption and expressing annoyance when the subject is mentioned.

7. Frequent absenteeism from the job, especially following weekends and holidays.

8. Repeated changes in jobs, particularly if to successively lower levels, or employment in a capacity beneath ability, education and background.

9. Shabby appearance, poor hygiene, and behavior and social adjustment inconsistent with previous levels or expectations.

10. Persistent vague physical complaints without apparent cause, particularly insomnia, stomach upsets, headaches, loss of appetite.

11. Multiple contacts with the health care system with disorders that are alcohol caused or related.

12. Persistent marital and family problems, perhaps with multiple marriages.

13. History of arrests for drunkenness or drunken driving.

Submitted by the KMA Impaired Physicians' Committee

Using a Questionnaire to Ascertain Hypertensive Patients' Knowledge

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Noncompliance is one reason why many Americans suffer from uncontrolled hypertension. Although patient education alone cannot guarantee improvement in patient compliance, it is assumed that those patients who have some knowledge of their disease and their treatment are more likely to comply with physicians' recommendations. In this study a questionnaire was administered to 352 hypertensive patients receiving medical care at a Community Health Center to determine what these patients knew about their illness and its treatment. Over 90% of those interviewed knew that salt, weight, and diet can influence blood pressure. Seventy-two percent knew that uncontrolled hypertension could cause cerebrovascular accidents, but only 10% mentioned kidney damage as a possible result of uncontrolled high blood pressure. Over 80% did not know what their last blood pressure reading was or what their normal blood pressure reading should be. Lastly, more than 50% of those interviewed did not know the names or the possible side effects of their antihypertensive medications.

Introduction

With the recent employment of more effective antihypertensive medication, there has been an increase in the number of hypertensive patients who are able to control their blood pressure (BP) and an observed decrease in mortality from cardiovascular and cerebrovascular diseases. However, there are still many Americans, especially many black Americans, who have uncontrolled hypertension either because their disease is undiagnosed, their hypertension is refractory, or the patients are noncompliant. Because hypertension is characteristically asymptomatic, noncompliance is more of an obstacle for the hypertensive patients than it is for those suffering from other chronic diseases.

Although patient education in and of itself cannot guarantee a change in behavior patterns or an improvement in patient compliance, it is assumed that patients are more likely to comply with physicians' recommendations if the patients have a basic understanding of their disease, know what their therapeutic regimen is and know why their treatment is necessary.[1,2] In their study at Johns Hopkins Hospital, David Levine et al reported that their educational program, which consisted of an exit interview, a home visit, and a series of three small group meetings, improved patient compliance; more importantly the number of patients in the experimental group who were able to control their BP increased by 28%.[3] Zismer et al reported in their study on education of hypertensive patients in private medical practice that the systolic BP of those patients participating in their educational program decreased by 13 mm Hg and that their diastolic BP decreased by 8 mm Hg while the BP of those patients in the control group rose slightly during the six month follow-up (3 mm Hg increase in systolic BP and 0.5 mm Hg in diastolic BP).[4]

At the Park DuValle Community Health Center (PDCHC), located in West Louisville, hypertension is the most commonly diagnosed disease. In order to improve the hypertensive educational program, to improve patient compliance, and to increase the hypertensive patients' ability to control their BP, a questionnaire was administered to those hypertensive patients seeking medical care at PDCHC to learn what these patients knew about their illness and their therapeutic regimen.

Patients & Methods

The earnings of 81% of the patients utilizing PDCHC are below 100% of the federal government's poverty guideline for family income. Approximately 92% of the patients served by the center live within a three mile radius of the facility and many come from low income, female-headed households. Eighty-one percent of those living in the PDCHC service area are black.[5]

The patients for our study were randomly selected from the ambulatory hypertensive patients who came to the adult clinic during a six week period. Three hundred and fifty-two patients were interviewed; three patients refused to answer the questions. Seventy-eight percent of those interviewed were female and 22% were male. The mean age was 59 years; the patients' ages ranged from 14 to 86 years. The standard deviation was ± 13.2 years.

In order to cause the least amount of inconvenience for the patients, the nursing staff, and the physicians, the questionnaire (Fig 1) was administered to the patients after they had registered and before they were taken to the examining rooms. By checking the diagnostic record in each chart, only those patients who had been

HYPERTENSION QUESTIONNAIRE

	YES	NO
1. Do you have high blood pressure? If yes, for how long? _____	☐	☐
2. What was your blood pressure reading the last time it was measured? _____		
3. What is your normal blood pressure reading supposed to be? _____		
4. How can high blood pressure hurt you if you don't do something to lower it? _____ _____		
5. Are you taking medicines to control your high blood pressure? If yes, which medicines? _____ _____ _____	☐	☐
6. Do you know if there are any possible side effects that your medicines may cause? Please list these side effects _____ _____ _____	☐	☐
7. Should you ever stop taking your high blood pressure medicine(s)?	☐	☐
9. Do some medicines affect people differently?	☐	☐
10a. Should you refill your blood pressure medicine before you run out of it?	☐	☐
10b. Can some foods people eat affect their blood pressure?	☐	☐
11. Do you add table salt or seasoning salt to your food?	☐	☐
12. Does salt affect your blood pressure?	☐	☐
13. Do you use pork, lard, bacon, or bacon grease to cook your food in?	☐	☐
13a. Do you smoke cigarettes?	☐	☐
14. Can daily problems (mental stress) affect your blood pressure?	☐	☐
15. Can your body weight affect your blood pressure?	☐	☐
16. Can physical activity or exercise help to lower your blood pressure?	☐	☐
17. Can high blood pressure be cured?	☐	☐
18. Do you feel comfortable asking your doctor questions about high blood pressure, your medicines, or anything else you want to know?	☐	☐
19. Do you know about the *free* blood pressure clinic held by the Health Department that measures your blood pressure for free, here in the basement of the clinic, every 2nd Monday of each month from 12:30 PM til 4:00 PM?	☐	☐
If yes, how did you find out? _____		
If yes, do you attend? _____		

Fig 1.

TABLE 1: NUMBER OF PATIENTS WHO ANSWERED 'YES' TO THE QUESTIONS.

	TOTAL (352)*	MALE (76)	FEMALE (276)	≤34 (15)	35-44 (38)	45-54 (67)	55-64 (94)	65-74 (95)	≥75 (43)
1.	327 (93%)	69 (91%)	258 (93%)	13 (87%)	35 (92%)	66 (99%)	90 (96%)	87 (92%)	36 (84%)
5.	325 (92%)	69 (91%)	256 (93%)	10 (67%)	36 (95%)	65 (97%)	90 (96%)	86 (91%)	38 (88%)
6.	113 (32%)	22 (29%)	91 (33%)	6 (40%)	14 (37%)	29 (43%)	34 (36%)	19 (20%)	11 (26%)
7.	23 (7%)	8 (11%)	15 (5%)	0 (0%)	6 (16%)	2 (3%)	4 (4%)	9 (9%)	1 (2%)
9.	310 (88%)	68 (89%)	242 (88%)	14 (93%)	34 (89%)	62 (93%)	85 (90%)	81 (85%)	34 (79%)
10a.	330 (94%)	68 (89%)	262 (95%)	12 (80%)	36 (95%)	63 (94%)	87 (93%)	92 (97%)	40 (93%)
10b.	341 (97%)	70 (92%)	271 (98%)	15 (100%)	37 (97%)	67 (100%)	91 (97%)	90 (95%)	41 (95%)
11.	196 (56%)	39 (51%)	157 (57%)	10 (67%)	24 (63%)	33 (49%)	52 (55%)	57 (60%)	20 (47%)
12.	331 (94%)	70 (92%)	261 (94%)	15 (100%)	36 (95%)	66 (99%)	90 (96%)	85 (89%)	39 (90%)
13.	128 (36%)	31 (41%)	97 (35%)	9 (60%)	20 (53%)	29 (43%)	25 (27%)	27 (28%)	18 (42%)
13a.	142 (40%)	35 (46%)	107 (39%)	9 (60%)	27 (71%)	35 (52%)	34 (36%)	26 (27%)	11 (26%)
14.	340 (97%)	71 (93%)	269 (97%)	15 (100%)	36 (95%)	66 (99%)	93 (99%)	90 (95%)	40 (93%)
15.	328 (93%)	68 (89%)	260 (94%)	14 (93%)	37 (97%)	63 (94%)	89 (95%)	86 (90%)	39 (91%)
16.	263 (75%)	62 (82%)	201 (73%)	13 (87%)	30 (79%)	50 (75%)	72 (77%)	70 (74%)	28 (65%)
17.	70 (20%)	20 (26%)	50 (18%)	8 (53%)	5 (13%)	17 (25%)	16 (17%)	21 (22%)	3 (7%)
18.	327 (93%)	74 (97%)	253 (92%)	13 (87%)	37 (97%)	62 (93%)	88 (94%)	88 (93%)	39 (91%)
19.	123 (35%)	18 (24%)	105 (38%)	6 (40%)	15 (39%)	25 (38%)	32 (34%)	28 (29%)	17 (40%)

*The number in parenthesis is the number of patients in each group.

diagnosed as being hypertensive were selected for the questionnaire. (Five of the subjects were diagnosed as having hypertension on the day of the interview). After explaining the purpose of the project, the patients were asked if they would be willing to answer some questions about high BP. Each question was read to the patients (sometimes the questions were reworded so the patients could understand what was being asked) and their responses were recorded. The correct answers to the questions were then discussed with the patients. In addition to recording their answers, the patients' age, sex and patient number were also recorded on each questionnaire. (Patient number was recorded to prevent questioning the same patient twice.)

Results

Table 1 shows the actual number of patients and the percentages of the patients in each group (total, male, female, and age groups) who answered *yes* to each of the questions: Table 2 depicts the actual number of patients and the per-

TABLE 2: NUMBER OF PATIENTS WHO ANSWERED 'NO' TO THE QUESTIONS.

	TOTAL	MALE	FEMALE	≤34	35-44
1.	18 (5%)	4 (5%)	14 (5%)	2 (13%)	1 (3%)
5.	25 (7%)	7 (9%)	18 (7%)	5 (33%)	2 (5%)
6.	218 (62%)	50 (66%)	168 (61%)	8 (53%)	21 (55%)
7.	317 (90%)	64 (84%)	253 (92%)	15 (100%)	30 (79%)
9.	14 (4%)	3 (4%)	11 (4%)	1 (6%)	1 (3%)
10a.	20 (6%)	7 (9%)	13 (5%)	3 (20%)	2 (5%)
10b.	3 (1%)	3 (4%)	0 (0%)	0 (0%)	0 (0%)
11.	156 (44%)	37 (49%)	119 (43%)	5 (33%)	14 (37%)
12.	15 (4%)	5 (7%)	10 (4%)	0 (0%)	1 (3%)
13.	223 (63%)	44 (58%)	179 (65%)	6 (40%)	18 (47%)
13a.	210 (60%)	41 (54%)	169 (61%)	6 (40%)	11 (29%)
14.	5 (1%)	2 (3%)	3 (1%)	0 (0%)	0 (0%)
15.	6 (2%)	3 (4%)	3 (1%)	0 (0%)	0 (0%)
16.	24 (7%)	4 (5%)	20 (8%)	0 (0%)	2 (5%)
17.	221 (63%)	43 (57%)	178 (64%)	6 (40%)	25 (66%)
18.	25 (7%)	2 (3%)	23 (8%)	2 (13%)	1 (3%)
19.	229 (65%)	58 (76%)	171 (62%)	9 (60%)	23 (61%)

	45-54	55-64	65-74	≥75
1.	1 (1%)	3 (3%)	6 (6%)	5 (12%)
5.	2 (3%)	3 (3%)	8 (8%)	5 (12%)
6.	36 (54%)	55 (59%)	69 (73%)	29 (67%)
7.	64 (96%)	86 (92%)	84 (88%)	39 (91%)
9.	3 (4%)	5 (5%)	3 (3%)	1 (2%)
10a.	4 (6%)	6 (6%)	3 (3%)	2 (5%)
10b.	0 (0%)	2 (2%)	0 (0%)	1 (2%)
11.	34 (51%)	42 (45%)	38 (40%)	23 (53%)
12.	1 (1%)	3 (3%)	8 (8%)	2 (5%)
13.	38 (57%)	69 (73%)	67 (71%)	25 (58%)
13a.	32 (48%)	60 (64%)	69 (73%)	32 (74%)
14.	0 (0%)	0 (0%)	3 (3%)	2 (5%)
15.	0 (0%)	1 (1%)	4 (4%)	1 (2%)
16.	2 (1%)	7 (7%)	8 (8%)	5 (12%)
17.	42 (63%)	58 (62%)	59 (62%)	31 (72%)
18.	5 (7%)	6 (6%)	7 (7%)	4 (9%)
19.	42 (63%)	62 (66%)	67 (71%)	26 (60%)

centages of patients in each group who answered *no* to each question, and Table 3 shows the actual number of patients and the percentages of patients in each group who answered *do not know* to each question. Table 4 contains the analysis of the patients' responses to the questions which could not be answered only with a yes, no, or do not know.

Although all the patients had been diagnosed as having hypertension according to their diagnostic record, 5% claimed that they did not have high blood pressure. Eighty-eight percent of these 18 patients were age 60 years or older. For those patients who could specifically identify how long they had been hypertensive, the average duration of their illness was 10.9 years; the range was one month to 55 years and the standard deviation was ±9.4 years. Eighty-two percent of those interviewed (290 patients) did not know what their last blood pressure reading was and 85% (300 patients) did not know what their normal blood pressure reading should be. (Any value for normal systolic pressure between 100-140 mm Hg and any value for normal dias-

TABLE 3: NUMBER OF PATIENTS WHO ANSWERED 'DO NOT KNOW' TO THE QUESTIONS.

	TOTAL	MALE	FEMALE	≤34	35-44
1.	7 (2%)	3 (4%)	4 (1%)	0 (0%)	2 (5%)
5.	2 (0%)	0 (0%)	2 (1%)	0 (0%)	0 (0%)
6.	21 (6%)	4 (5%)	17 (6%)	1 (6%)	3 (8%)
7.	12 (3%)	4 (5%)	8 (3%)	0 (0%)	2 (5%)
9.	28 (8%)	5 (7%)	23 (8%)	0 (0%)	3 (8%)
10a.	2 (0%)	1 (1%)	1 (0%)	0 (0%)	0 (0%)
10b.	8 (2%)	3 (4%)	5 (2%)	0 (0%)	1 (3%)
11.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
12.	6 (2%)	1 (1%)	5 (2%)	0 (0%)	1 (13%)
13.	1 (0%)	1 (1%)	0 (0%)	0 (0%)	0 (0%)
13a.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
14.	7 (2%)	3 (4%)	4 (1%)	0 (0%)	2 (5%)
15.	18 (5%)	5 (7%)	13 (5%)	1 (6%)	1 (3%)
16.	65 (18%)	10 (13%)	55 (20%)	2 (13%)	6 (16%)
17.	61 (17%)	13 (17%)	48 (17%)	1 (6%)	8 (21%)
18.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)
19.	0 (0%)	0 (0%)	0 (0%)	0 (0%)	0 (0%)

	45-54	55-64	65-74	≥75
1.	0 (0%)	1 (1%)	2 (2%)	2 (5%)
5.	0 (0%)	1 (1%)	1 (1%)	0 (0%)
6.	2 (3%)	5 (5%)	7 (7%)	3 (7%)
7.	1 (1%)	4 (4%)	2 (2%)	3 (7%)
9.	2 (3%)	4 (4%)	11 (12%)	8 (19%)
10a.	0 (0%)	1 (1%)	0 (0%)	1 (2%)
10b.	0 (0%)	1 (1%)	5 (5%)	1 (2%)
11.	0 (0%)	0 (0%)	0 (0%)	0 (0%)
12.	0 (0%)	1 (1%)	2 (2%)	2 (5%)
13.	0 (0%)	0 (0%)	1 (1%)	0 (0%)
13a.	0 (0%)	0 (0%)	0 (0%)	0 (0%)
14.	1 (1%)	1 (1%)	2 (2%)	1 (2%)
15.	4 (6%)	4 (4%)	5 (5%)	3 (7%)
16.	15 (22%)	15 (16%)	17 (17%)	10 (23%)
17.	8 (12%)	20 (21%)	15 (15%)	9 (21%)
18.	0 (0%)	0 (0%)	0 (0%)	0 (0%)
19.	0 (0%)	0 (0%)	0 (0%)	0 (0%)

tolic pressure between 70-90 mm Hg was accepted as correct. The patients had to respond with both a correct systolic and a correct diastolic pressure in order for them to be counted as *knowing* their normal blood pressure.) Fifty-seven percent (184 patients) did not know the name of any of their antihypertensive medications and only 32% (113 patients) knew that medicine could have side effects. When asked about the possible result of uncontrolled hypertension, 72% (255 patients) responded that they could have a stroke; 41% (133 patients) mentioned the possibility of heart problems; but only 17% (35 patients) knew that kidney damage could be the result of their not lowering their blood pressure. Over 90% knew that diet, weight, and stress could influence blood pressure. Ninety-four percent (330 patients) knew that salt affects blood pressure, but 56% (196 patients) said they added salt to their food, and 36% (128 patients) reported that they seasoned their food with salted pork. Several patients commented that they had decreased the amount of salt and pork used in cooking since being diagnosed as

hypertensive. Forty percent (142 patients) smoked cigarettes. Lastly, only 35% of those interviewed (123 patients) knew about the free blood pressure monitoring clinic sponsored by the Louisville and Jefferson County Board of Health at PDCHC; and, of those who knew about it, 86% of them (106 patients) did not attend this free blood pressure clinic.

The data was also analyzed according to age and sex. There were no statistically significant differences in the responses of the male patients versus the female patients. However, there was an interesting difference in patients' response when classified according to age. Fifty-three percent of those under the age of 35 years answered that hypertension could be cured while only 20% of the total number of interviewed patients believed that high blood pressure was curable. Because only 15 patients age 34 years or under were interviewed and three of them were newly diagnosed hypertensive patients who had been referred to the interviewer by the nursing staff, this high percentage may be a result of a small sampling size rather than a general lack of knowledge.

TABLE 4: PATIENTS' RESPONSES TO QUESTIONS 4, 5, 6 AND 19.

Question 4: Deleterious effects of Hypertension

Stroke: 255 (72%)	Dizzy: 33 (9%)
Heart: 133 (41%)	Vision: 20 (6%)
Kidney: 35 (9%)	*Do not know*: 16 (15%)
	Others: 66 (19%)

Question 5: Current Medications for Hypertension

HCTZ: 51 (16%)	Aldomet: 13 (4%)
Water pill: 27 (8%)	Minipress: 11 (3%)
Inderal: 19 (6%)	Clonidine: 7 (2%)
K+: 16 (5%)	Procardia: 6 (2%)
Catapress: 27 (8%)	Visken: 6 (2%)
Lasix: 14 (4%)	Furosemide: 6 (2%)
	Others: 14 (4%)

Question 6: Side Effects of Medications

Drowsy (Sleepy): 16 (14%)	Headache: 6 (5%)
Dry Mouth: 9 (8%)	Fatigue: 5 (4%)
Dizzy: 8 (7%)	Impotency: 4 (4%)
Lose K+: 8 (7%)	Itch: 3 (3%)
	Others: 36 (31%)

Question 19: How Patients Learned of *Free* HBP Clinic

Sign Posted: 51 (41%)	Friend: 4 (3%)
Heard Talk: 16 (13%)	Told by Relatives: 3 (2%)
TV: 11 (9%)	Told by a Physician: 2 (2%)
Here: 11 (9%)	Read About It: 2 (2%)
Received a Card: 8 (6%)	Fliers: 2 (2%)
	Others: 11 (9%)

Conclusions

By administering the questionnaire to the hypertensive patients at PDCHC, it was learned that the patients know that diet, weight, stress, and salt can influence blood pressure. It was also discovered that a majority of the patients did not know what their last blood pressure reading was, what their normal blood pressure should be, or what the names or the possible side effects of their antihypertensive medications are. These results concur with the results obtained by Laher et al in 1981 when they administered a questionnaire to 46 hypertensive patients who had previously received a high blood pressure booklet to read. Laher et al found that only a few of their patients understood what was meant by the blood pressure readings and that virtually none of them understood about the possible side effects of their antihypertensive medications.[1]

By learning what hypertensive patients know and do not know about their disease, it is hoped to improve the PDCHC educational program, to increase patient compliance, and to decrease the hypertensive patients' morbidity and mortality.

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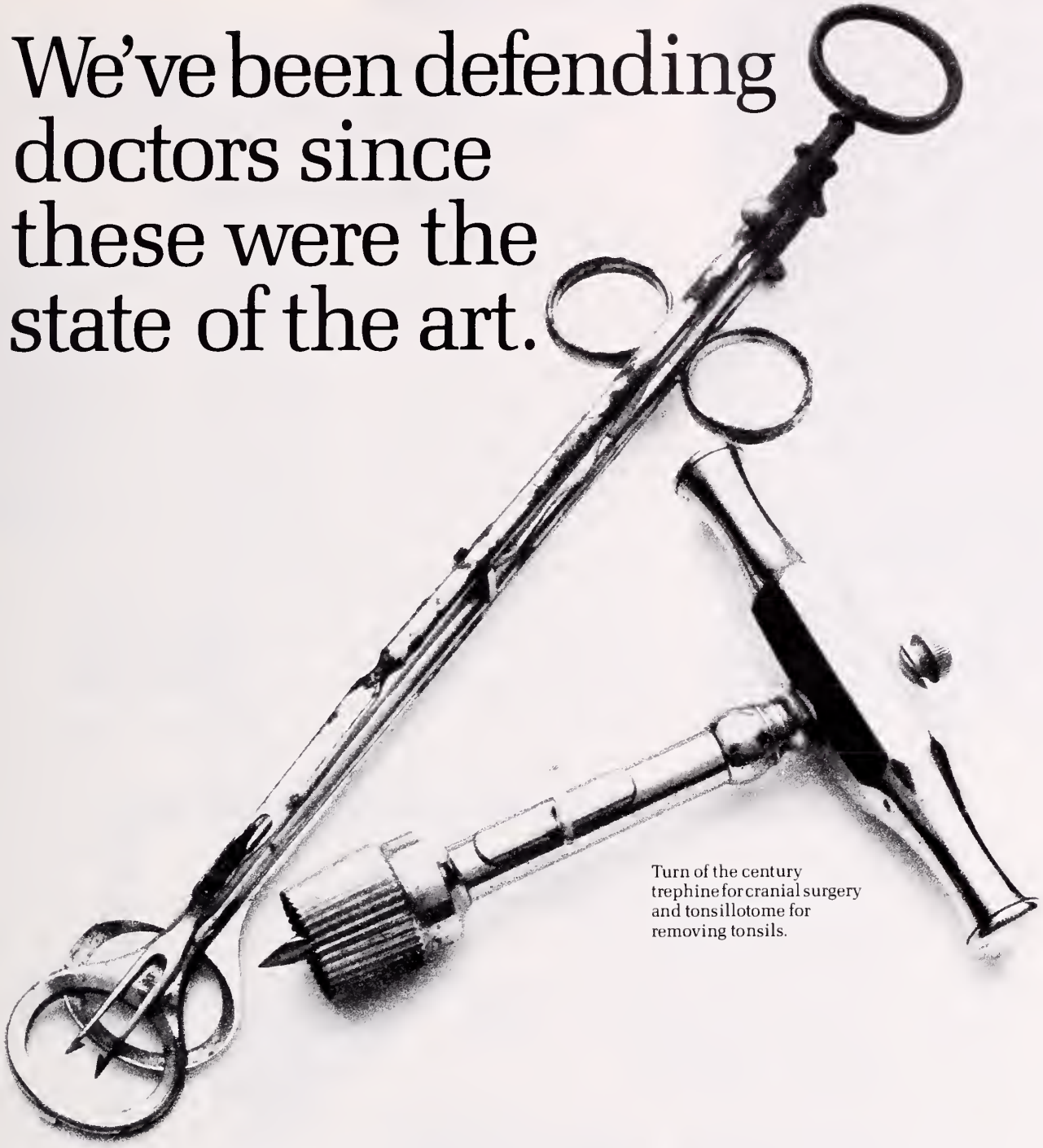
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Hyperthyroid Crisis

Donald E. Barker, MD
William E. Strodel, MD

Donald E. Barker, MD, Assistant Professor of Surgery, and William E. Strodel, MD, Professor of Surgery, Department of Surgery, Albert B. Chandler Medical Center, University of Kentucky, Lexington, KY 40536-0084.

A 23-year-old woman was referred to the Chandler Medical Center Trauma Surgery Service complaining of left upper quadrant abdominal pain after a motor vehicle accident. Upon arrival her blood pressure and pulse were elevated at 154/92 mm Hg and 134 bpm respectively. Respirations and temperature were normal. Physical examination showed left upper quadrant abdominal wall ecchymosis and tenderness to palpation, minor soft tissue facial injuries, and palpable thyroid enlargement. No signs of cervical spine, facial, or thoracic injury were detected on plain radiographs. Her hematocrit had decreased from 37 vol% at the referring hospital to 31 vol%. Routine admission blood and urine chemistries were unremarkable. An electrocardiogram demonstrated sinus tachycardia without signs of myocardial injury. Contrast enhanced computerized axial tomography of the abdomen demonstrated a grade II laceration of the inferior splenic pole and free intraperitoneal fluid. Because of persistent tachycardia and a falling hematocrit, the patient underwent exploratory laparotomy and splenorraphy on the day of admission. Intraoperatively, the blood pressure varied from 90/50-170/85 mm Hg, the heart rate varied from 130-150 beats per minute, and the temperature remained normal.

Tachycardia persisted in the initial postoperative period without signs of intravascular volume depletion, cardiac injury, or hypoxia. A clinical diagnosis of hyperthyroidism was made on the basis of palpable thyroid enlargement and unexplained tachycardia. Parenteral esmolol hydrochloride was empirically administered intravenously at 50 mcg/kg/min and increased sequentially to 300 mcg/kg/min. The heart rate decreased from 150 to 120 bpm. With the concomitant administration of propranolol 60 mg po qid the heart rate decreased to 100 bpm. Blood samples for subsequent thyroid function testing were obtained prior to initiation of therapy. The results, returned 72 hours after initiation of therapy, showed a T3 of 139 ng/dl (nl 100-200 ng/dl), a T4 of 15 mcg/dl (nl 5-12 mcg/dl), and a TSH of 0.2 mu/ml (nl 0.9-4.6 mu/ml) confirming the clinical diagnosis of hyperthyroidism. No other postoperative complications occurred and the patient was discharged on the 11th postoperative day. Discharge medications included propranolol 60 mg po qid and propylthiouracil 100 mg tid. At the time of discharge the heart rate was 90 bpm and the patient was asymptomatic.

Discussion

Thyroid hormone is produced by the thyroid gland under control of the hypothalamic-anterior pituitary axis. Thyroid releasing factor (TRF) is transported from the hypothalmus to the anterior pituitary axis. Thyroid releasing factor (TRF) is transported from the hypothalmus to the anterior pituitary where it activates secretion and synthesis of thyroid stimulating hormone (TSH), the major regulator of thyroid hormone synthesis and release. Thyroid hormone synthesis begins in the thyroid follicular cells where iodine is actively concentrated and organified with thyroglobulin to form the thyroid hormone precursors, mono- and diiodotyrosines. These precursors are then coupled to form hormonally active triiodothyronine (T3) and thyroxine (T4) and released into the blood stream.[1]

The signs and symptoms of hyperthyroidism result from the effects of elevated circulating thyroid hormone levels on metabolism and the cardiovascular and sympathetic nervous systems. Thyroid hormone stimulates protein synthesis, regulates the hyperglycemic effects of epinephrine, potentiates the effects of insulin and influences lipid metabolism producing a decrease in serum cholesterol and phospholipids. Its metabolic effects result in an increased metabolic rate with increased oxygen consumption, calorigenesis, and elevation of body temperature.[1] Increased levels of serum thyroid hormone result in a sympathomimetic effect. Cardiovascular effects are due to both an exaggerated response of the cardiovascular system to catecholamines and a direct, catecholamine-independent, influence on the heart.[2]

The physical signs of hyperthyroidism include thyroid gland enlargement, tachycardia, fever, skin changes, tremor, and mental status changes. Common symptoms include nervousness, heat intolerance, palpitations, fatigue, increased perspiration and weight loss. In the acutely injured patient, these signs and symptoms may go unrecognized or be attributed to the stress of injury or operation. Left untreated, the thyrotoxic patient may develop hyperthyroid crisis.

Hyperthyroid crisis can occur in any patient with underlying thyrotoxicosis. Precipitating factors include withdrawal of thyroid medication, trauma, surgery, parturition, diabetic ketoacido-

sis, infection, and venous or arterial thromboembolism.[3] Typical physical findings include fever > 100 degrees F, tachycardia > 130 bpm, and alteration in level of consciousness. Tachycardia may progress to arrythmias, congestive heart failure, and pulmonary edema. Restlessness or psychosis may progress to stupor or coma. Gastrointestinal complaints of anorexia or nausea may progress to vomiting and diarrhea producing dehydration.[4] Many laboratory abnormalities have been associated with hyperthyroid crisis including leucocytosis with a left shift, hypokalemia, hyperglycemia, anemia, pyuria, and hypocarbia. T3 and T4 levels are elevated, but treatment must be initiated before these results are available because untreated thyroid storm is rapidly fatal.[3]

A thorough but rapid evaluation should be undertaken to identify other causes for the patients signs and symptoms. Sources of sepsis should be sought and treated. Malignant hyperthermia should be considered and if diagnosed treated appropriately. Pheochromacytoma may present with tachycardia and hypertension. If suspected, care must be taken to avoid beta blocking agents prior to alpha blockade.

When the tentative diagnosis of thyrotoxic crisis has been made, therapy is directed toward treatment of the inciting illness or injury, reduction of thyroid hormone synthesis and secretion, suppression of the metabolic effects, and general supportive measures.[3]

Iodine has long been recognized as an effective means of reducing thyroid hormone secretion. It may be administered either internally as a saturated solution of potassium iodide or parenterally as sodium iodide solution. Administration should be delayed one hour after administration of a thyroid antimetabolite drug, to prevent uptake of iodide by the unblocked thyroid gland.[3] The thyroid antimetabolite drugs, propylthiouracil and methimazole, block thyroid hormone synthesis within the thyroid gland. Propylthiouracil also inhibits peripheral conversion of T4 to T3.[3]

The metabolic effects of thyroid hormone may be successfully blocked with antiadrenergic agents. Propranalol acts rapidly (2-10 minutes IV or one hour orally) and is effective in controlling the cardiovascular and psychomotor manifestations of thyrotoxicosis and hyperthyroid crisis.[5,6,7,8] Although propranalol has supplanted guanethidine and reserpine in the management of thyrotoxic crisis, a recent report describes the successful use of reserpine in propranolol-resistant thyroid storm.[9] Esmolol, an ultra-short-acting intravenous cardioselective beta blocker, is unproven in thyroid storm, but may be preferable to intravenous propranolol because of its rapid onset of action and its short half life (about nine minutes).[10]

Supportive measures include temperature reduction, hydration, supplemental oxygen, sedation, administration of multivitamins, and steroids. Fever is controlled with cooling blankets and antipyretics. Aspirin, which displaces thyroxine from serum proteins,[11] should be avoided; acetaminophen is preferred. Glucose containing intravenous fluid should be infused in quantities sufficient to maintain urinary output. Central venous or pulmonary capillary wedge pressure should be monitored if cardiac disease is known or suspected. Although corticosteroid therapy is frequently recommended, published evidence of improved outcome due to steroids is sparse.[12] Dexamethasone has been shown to lower thyroxine and triiodothyronine levels in Graves' disease patients not in storm.[13] It is not clear whether the potential benefits of steroids outweigh their side effects of immunosuppression and impairment of wound healing.

Usually, the diagnosis of hyperthyroidism is based on the results of history and physical exam and confirmed by serum T3, T4, and TSH levels before treatment is initiated. However, as this case presentation illustrates, the signs and symptoms of hyperthyroidism may be subtle and easily attributed to the stress of injury or operation. In the acutely injured patient a history of hyperthyroidism may not have been established prior to injury or may be unobtainable. The only clinical findings suggestive of hyperthyroidism may be unexplained tachycardia and fever. Confirmatory laboratory results of serum thyroid function studies may not be available for several days. Left unrecognized and untreated hyperthyroidism may progress to hyperthyroid crisis with its attendant high mortality.

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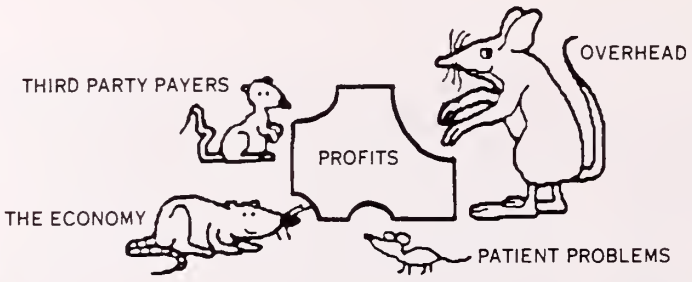
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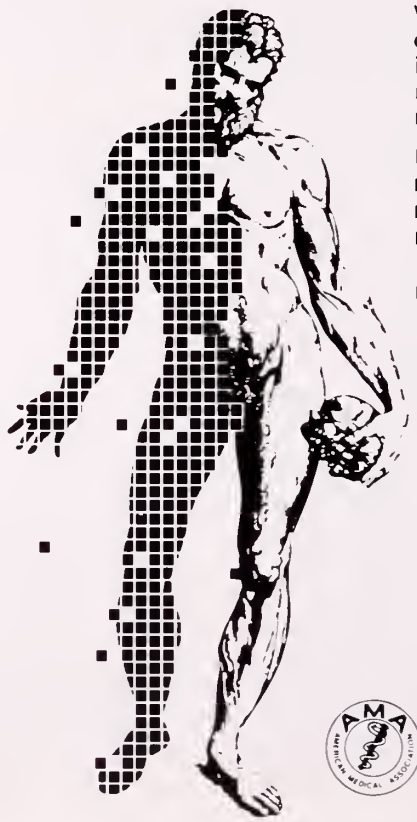
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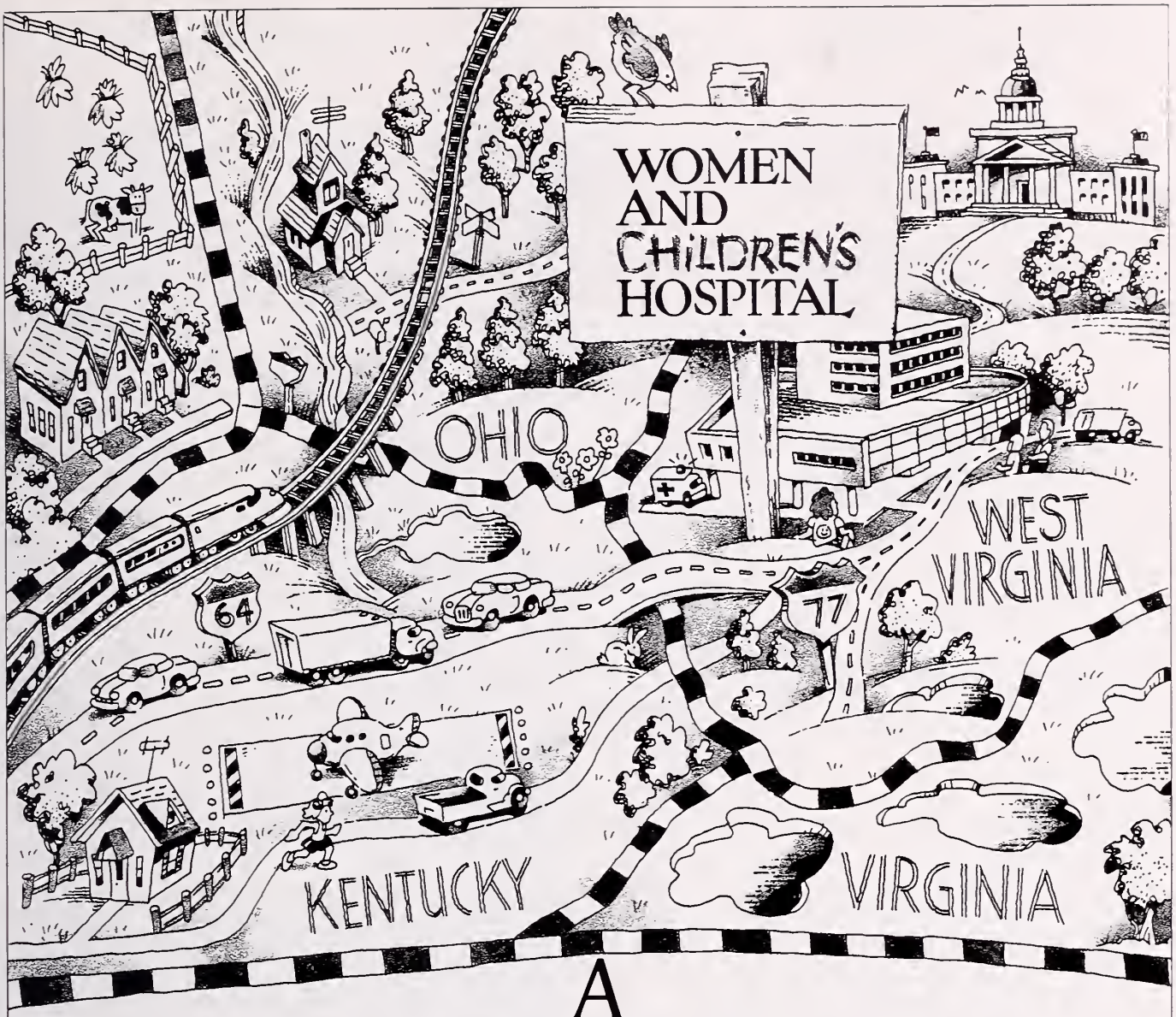
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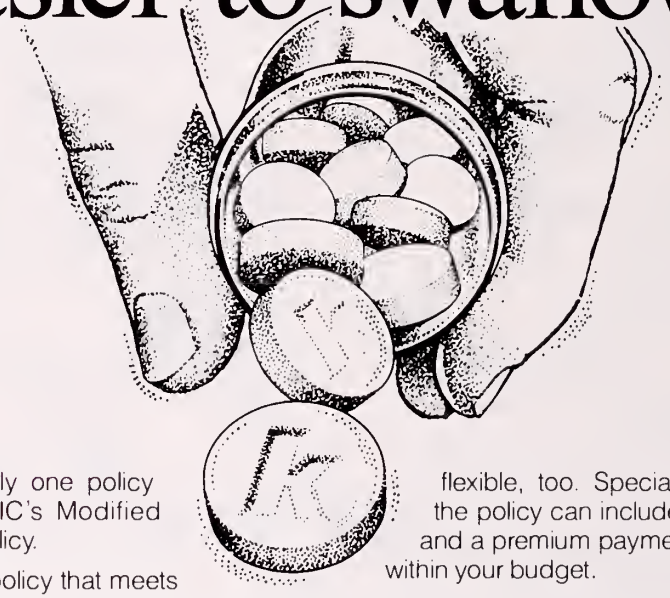
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ALLAN J. HAMILTON, M.D.

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RESIDENCY General Surgical Internship. Neurosurgical Residency, Massachusetts General Hospital.

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OUTSTANDING ACHIEVEMENTS Olsen Memorial Fellowship, National Masonic Medical Research Foundation; Albert Schweitzer Fellowship, International Albert Schweitzer Foundation; Harvard Medical School Cabot Prize for Best Senior Thesis; recently published article, "Who Shall Live and Who Shall Die" in Newsweek Magazine.

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3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

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Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live tetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGDT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGDT, SGPT enzymes (greater than 500 tU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

PV 2091 AMP [041288]

Axid® (nizatidine, Lilly)

Eli Lilly and Company
Indianapolis, Indiana
46285

NZ-2903-B-849356

© 1988, ELI LILLY AND COMPANY

Our Children

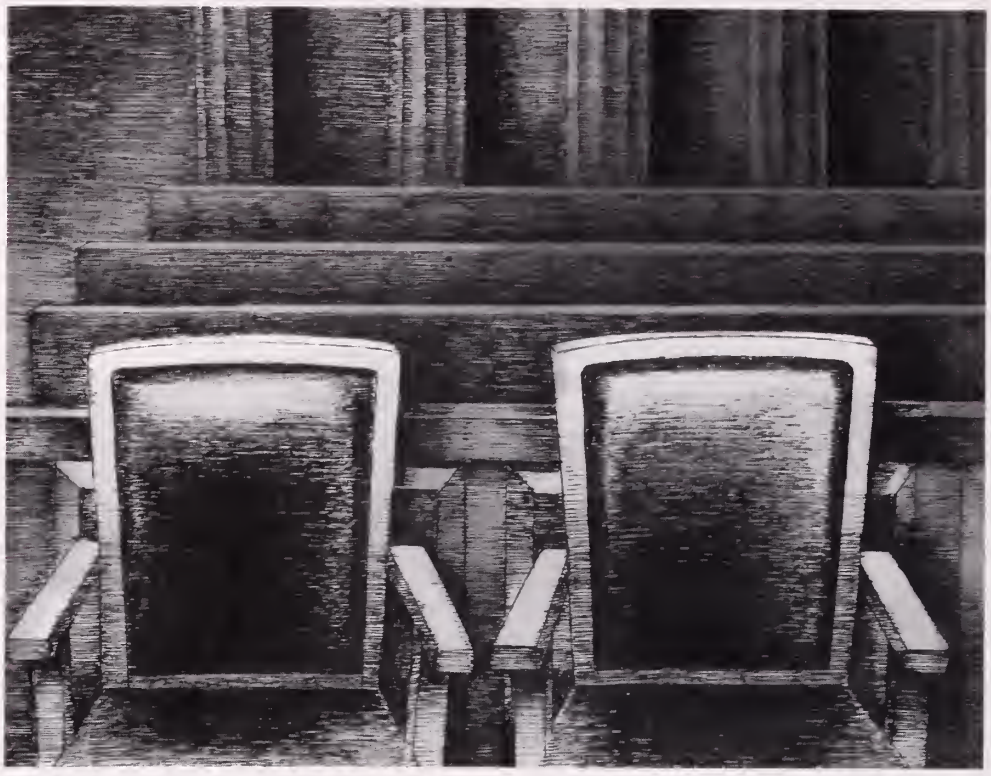
Dr Whelan's article begins on page 353.

A 27-year-old woman has intermittent attacks of pain in the left lower quadrant of her abdomen. All studies, including gastrointestinal x-rays, are normal except for small gallstones. After cholecystectomy her pains subside. A 25-year-old woman has episodes of midabdominal pain. She wants to become pregnant for the first time. Gastrointestinal x-rays are postponed for several months and are finally performed during a menstrual period. The examinations are normal, she feels reassured and the pains do not recur.

This issue of the *Journal* publishes a fine article by Doctor Jay Whelan entitled, "Diagnostic Radiology in Fertile or Pregnant Women." This paper has importance beyond its scope. While too many patients lack the interest or motivation to avoid such obvious toxins as cholesterol and smoke, many others fear too greatly the silent and treacherous invasion of irradiation. It is to be expected in a climate of the tragedy of Chernobyl and the cessation of Marble Hill's creation that fear of such obvious sources of ionizing radiation as medical examinations should abound. Those of us who are not radiologists need the reassurance and confidence of Doctor Whelan's information to proceed in the judicious care of our patients.

We also want to protect our children from the moment of their conception. That is why we do not smoke or drink during pregnancy.

A. Evan Overstreet, MD
Editor



Today, one doctor in four will face a malpractice claim or suit.

Odds are increasing that you could wind up in court. Or you might spend your valuable time trying to negotiate a settlement through a claims adjuster.

If this was a disease, it would be considered an epidemic.

PIE Mutual takes medical liability insurance seriously, because we have to. We're a physician-owned and operated underwriter serving the exclusive needs of our member physicians and dentists.

Our claims-handling policy demands that each claim or suit be examined by five physician specialists in the area of the claim. And, no claim is settled until a physician review committee authorizes payment.

Our aggressive defense team is comprised of seasoned veteran attorneys with experience in all areas of medical liability claims. Over the past 12 years they have chalked up an outstanding record for our member insureds.

Before your odds are up, call on our experts and get the benefit of the PIE Mutual defense program.

The PIE Mutual Insurance Company
The Galleria & Towers at Erieview
1301 East Ninth Street
Cleveland, OH 44114
(216) 781-1087

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Lexington, KY 40508
606/253-1371

E.M. FORD & COMPANY
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Owensboro, KY 42302
502/926-2806

HIGGINS INSURANCE, INC.
800 S. Virginia Street
P.O. Box 5
Hopkinsville, KY 42240
502/886-3939

NEW RIVER INSURANCE ASSOCIATES, INC. OF ASHLAND
1536 Winchester Avenue
Suite 222
Ashland, KY 41105
606/324-9039

NUNN INSURANCE SERVICES, INC.
129 E. Main Street
Horse Cave, KY 42749
502/786-2234

FREDERICK RAUH COMPANY OF KENTUCKY
211 Grandview Drive
Ft. Mitchell, KY 41017
606/341-5722

UNITED INSURANCE SERVICES, INC.
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Suite 1001
Louisville, KY 40299
502/499-6880

VAN METER INSURANCE
1719 Ashley Circle
P.O. Box 1779
Bowling Green, KY 42101
502/781-2020

VAUGHN INSURANCE AGENCY COMPANY
315 N. Main Street
P.O. Box 458
Henderson, KY 42420
502/827-3505

WESTERN RIVERS CORPORATION
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P.O. Box 1480
Paducah, KY 42002
502/442-3533

WOOD UNDERWRITER AGENCY, INC.
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Cincinnati, OH 45202
513/852-6300

Legislative Know-How!

MONDAY
September 26, 1988
2-4 PM

Lexington Hyatt Regency
Chicago/Atlanta Rooms

Open to all KMA
Attendees and Spouses



"The Time to Get Involved is Now!!"

Presented by Susan Bryant —

- *President of Research/Strategy/Management, Inc., a Washington based political consulting firm*
- *Former political director of the National Republican Senatorial Committee*
- *Former faculty member of the Republican Campaign Management College*
- *Member of advisory council of the Responsible Government for American Foundation*
- *Author of professional journal on scheduling for political candidates*
- *Seminar leader throughout the nation for political groups, corporations, trade associations*
- *Recognized by press as expert on women's voting patterns, having authored, with Dr. Vince Breglio, the definitive study of the gender gap in 1983.*

Carol Franks
AKMA President

C L A S S I F I E D S

RATES AND DATA

All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

BOARD ELIGIBLE INTERNIST — to join a busy two-physician practice in Lexington. Send curriculum vitae to PO Box 22734, Lexington, KY 40522-2734.

*** 2V STAT STAT STAT STAT STAT STAT STAT *** — software and knowledge base for diagnoses and treatment, covering 69 different medical specialties. $95 for demo disk. The more you know, the better you treat. The most updated medical algorithms at your fingertips!!! 2V MedTech Corporation, 2480 Windy Hill Road, Suite 201, Marietta, GA 30067. (404) 956-1855; Telex 551341Medvideo.

INTERNIST — IMMEDIATE OPENING. Beautiful historic small college town in Central Kentucky. Must be BC/BE and proficient in coronary/intensive care management. Established practice with two other internists. Excellent salary and benefit package with full partnership after one year. Send CV to Physician Recruitment Coordinator, Berea Hospital, Estill Street, Berea, KY 40403.

FAMILY PRACTICE — IMMEDIATE OPENING. BC/BE to join 2 FPS in growing practice in a beautiful historic small college town in Central Kentucky. Excellent salary and benefit package. Send CV to Physician Recruitment Coordinator, Berea Hospital, Estill Street, Berea, KY 40403.

MAXICARE LOUISVILLE — Maxicare has open positions in Internal Medicine, Pediatrics, Family Practice, and OB/GYN. We serve 35,000 members in five well-equipped medical offices. Excellent salary and fringe benefits. Shared call, as well as four and one-half day office schedules allow ample time for other interests and responsibilities. For confidential consideration, please submit curriculum vitae to: John Crum, MD, Medical Director, Maxicare Louisville, 303 N Hurstbourne Lane, Suite 200, Louisville, KY 40222, (502) 429-4611.

INTERNAL MEDICINE PRACTICE FOR SALE — Average Gross 12% above national average. Average Net 15% above national average. Located in East Central portion of State. For more information contact: RH Medical Group (713) 496-7777.

FAMILY PRACTITIONER — To join two other family physicians in a busy, downtown neighborhood practice. Full range of family medicine excluding obstetrics. Please contact: Pat Murphy, MD, 330 East Oak Street, Louisville, KY 40203, (502) 636-2833.

GENERAL INTERNIST, BC/BE — Lexington Clinic's Section of Internal Medicine is seeking a seventh internist. Competitive Salary, benefits and partnership is offered. Send CV to: William Wittman, MD, Lexington Clinic, 1221 South Broadway, Lexington, KY 40504.

WESTERN KENTUCKY — Seeking physicians for evening and weekend coverage in a low volume emergency department. Attractive schedule and compensation. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 31, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

8 PHYSICIANS WANTED — in South Louisville: 4 Family Practitioners, BE/BC Internist, Invasive Cardiologist, Gastroenterologist and Ophthalmologist. Great opportunity for young practitioners to join one of several different established practices or assume private practice of retiring physicians. Area offers modern hospital and office facilities with superior compensation and benefit packages. Serious inquiries only. Mail CV to Recruitment Manager, 5821 Pine Mountain Drive, #E, Louisville, KY 40214.

VACATION: ISLA DEL SOL ISLAND — St. Petersburg Beach area, 2 bedroom, 2 bath garden villa on the pool, waterfront view (Tampa Bay), 18-hole golf course, 90 minutes to Disneyworld, $500 per week. Contact: E. Dougherty 502-228-0035.

To the Editor:

Marketing of medical services and solicitation for patients has apparently become a reality of the practice of medicine in today's highly competitive environment. Unfortunately urologists seem to be leading the recent charge of medical advertising. We have recently seen large newspaper advertisements for impotence centers, infertility clinics, lithotripsy services, and recently an incontinence clinic. Many of these ads are nothing more than solicitations for patients. Some promise special expertise and up-to-date, state-of-the-art technological expertise. Sometimes claims of expertise are unwarranted and special expertise is having attended a recent weekend course. To comply with medical ethics, some physicians try to hide behind the name of hospitals who are the sponsors of the advertisements, but any knowledgeable physician can tell which physician or group is behind a given advertisement. Only the public may be unaware of this hypocrisy.

Frequently, large capital investments in advertising and marketing budgets and in equipment are necessary for these campaigns. This cost must be passed on to the consumer. While an unsuspecting public might be hornswoggled by outlandish claims of competency, success and expertise, the practicing physician should remain aware that many of these so-called centers are nothing more than slick appeals directly to patients, disrupting established time-tested lines of referral. In most instances, identical services are available from traditional providers at a lesser expense.

Greedy physicians might be tempted to over-utilize unproven and unwarranted technology to defer capital expenses.

If advertisements for physicians' services are to appear in public places much like disreputable attorneys, then the only recourse to stop this expensive and potentially clinically unjustified administration of medical services is for responsible and ethical physicians to shun these greedy snake oil vendors.

Prostatic ultrasound is a new technological application for evaluation and confirming the presence of abnormal lesions of the prostate. It is not intended as the sine qua non of prostatic examination and it is not to replace a careful clinical history or rectal palpation of the prostate and other diagnostic testing. The unwarranted broad application of prostatic ultrasound to the examination of all patients is to be deplored and condemned, as are other forms of whimsical medical marketeering designed to capture a broader patient base.

Mohammad Amin, MD, FACS
210 Medical Towers, North
Louisville, KY 40202

James R. Stivers, MD, FACS
Suite 1129, Medical Arts Building
1169 Eastern Parkway
Louisville, KY 40217

KMA Board of Trustees
Spring Meeting



KMA Board of Trustees

The KMA Board of Trustees held its third meeting of the Associational year on April 20-21, 1988, at the KMA Headquarters Building in Louisville.

The Board members heard reports from the President, the President of the Auxiliary to KMA, the Secretary of the Board of Medical Licensure, and the Commissioner for Health Services.

The Secretary-Treasurer, S. Randolph Scheen, MD, reported that the Hospital Medical Staff Section would meet on June 16, and would feature an address by James Todd, MD, Deputy Executive Vice President of the AMA. Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities, presented a comprehensive report on the recently completed Kentucky General Assembly, which detailed KMA's successes in the area of civil justice/liability insurance reform, House of Delegates' directives, and other health and medical legislation. Doctor Montgomery was presented with a plaque in appreciation for his many hours of service on behalf of the profession.



A. Evan Overstreet, MD, was recognized for his fine efforts as Editor of the Journal. President Donald C. Barton, MD, presented him with a bound volume of the past year's issues.



Chairman William B. Monnig, MD, presented Wally O. Montgomery, MD, with a plaque in appreciation for his many hours of service on behalf of the profession.

Several other presentations were also made, including a plaque to Fred C. Rainey, MD, Senior Delegate to AMA, for his work at the AMA level, and a set of bound *Journals* to Editor, Evan Overstreet, MD. It was reported that a plaque had also been prepared for Richard F. Hench, MD, in appreciation for his service during the past two years on the Kentucky Insurance Liability Task Force.

The Board members adopted the Budget as proposed for the 1988-89 fiscal year, and further adopted a recommendation of the Budget Committee that the Board recommend to the House of Delegates that dues remain at $400, with $25 per member earmarked for the PLI fund.

A slate of nominees was approved for appointment to the KMIC Board of Directors, and the Board Chairman was authorized to appoint an ad hoc committee to study the selection process of the KMIC Board. Nominees were finalized for submission to the Governor for the Kentucky Board of Medical Licensure, and the Board approved a Resolution for introduction into the 1988 House of Delegates regarding requirements for hospital medical staff membership, which had been modified following referral by the House in 1987. In followup to another Resolution adopted by the 1987 House, it was noted that KMA officers would meet with the Commissioner of Insurance to discuss concerns relating to managed healthcare plans.

The Board supported the concept of a Task Force appointed by the Governor to address the nursing shortage, and agreed to appoint a representative to such a Task Force, if one was formed.

The next meeting of the Board of Trustees was scheduled for August 10-11.



Fred C. Rainey, MD, Senior Delegate to AMA, was the recipient of a plaque for his work at the AMA level.



KMA Auxiliary President Pamela Potter, Ashland, advised the Board that the University of Louisville had received $24,565.35 and the University of Kentucky $16,657.39 from last year's AMA-ERF contributions.



A plaque, earned by Medical Student Section Presidents Baretta Casey (UK) and Terry Cleaver (UofL) for "Outstanding Membership Recruitment" of AMA-MSS members, was presented to the Dean of each of the medical schools. (L to R) UK Interim Dean Emery Wilson, MD; Baretta Casey; Terry Cleaver; and UofL Dean Donald Kmetz, MD.

Committees



Doctor Robert R. Goodin of Jefferson County (head of table) serves as Chairman of the Physician Manpower Committee.

Members of the **Physician Manpower Committee** met on March 31 to discuss the distribution of physicians in Kentucky and to study factors considered important to young physicians when choosing practice locations. Chaired by Robert R. Goodin, MD, Louisville, the committee is assisted in its research by the Council on Higher Education, the Cabinet for Human Resources and both medical schools.



Venkateswara R. Goli, MD, of Perry County.

At its March 31 meeting, the ad hoc **Committee on Foreign Medical Graduates** met to discuss broader representation of FMGs in organized medicine. Members of the committee agreed that active participation should be encouraged through committee appointments and election to leadership positions. A representative from the Board of Medical Licensure was invited to the meeting to discuss licensure requirements in Kentucky and to explain the procedure involved in application for licensure.



(L to R) Alfred L. Thompson, Jr, MD, Louisville; Todd Pesavento, incoming Medical Student Section President for the University of Louisville School of Medicine; and Syed M. Nawab, MD, Louisville.

Notice on Physician Advertising

In 1983, the Judicial Council developed and published Voluntary Guidelines for Physician Advertising. These guides were intended to help physicians make decisions about advertising in the wake of changes to the Code of Ethics of the AMA. The AMA Code was changed as the result of a Federal Trade Commission investigation and a suit filed against the AMA alleging restraint of trade.

In the course of an interchange with the FTC, KMA's Voluntary Guidelines have come into question. Accordingly, the Board of Trustees has revoked the Voluntary Guidelines. For the guidance of the membership relating to advertising, Kentucky Revised Statute 311 is suggested and Kentucky Administrative Regulation 201 KAR 9:018, which appears below, published by the Kentucky Board of Medical Licensure.

201 KAR 9:018. Physician advertising

RELATES TO: KRS 311.530 to 311.620, 311.990

PURSUANT TO: KRS Chapter 13A

NECESSITY AND FUNCTION: This regulation delineates limits of permissible professional advertising with the aim of adequately informing the public about physician services while at the same time establishing safeguards to protect the public or any member thereof from false, fraudulent, misleading, deceptive, self-laudatory or unfair statements.

Section 1. This regulation shall apply to all physicians licensed to practice medicine or osteopathy in the Commonwealth. It shall apply in regard to all advertising of whatever type and wherever published.

Section 2. Advertising may be by any medium provided that the advertisement is not in any manner fraudulent, misleading or deceptive.

Section 3. The following may not be advertised:

(1) Testimonials of patients as to the physician's skill or the quality of his or her professional services;

(2) Claims regarding the physician's experience, competency and quality of services which imply that he or she possesses an exclusive and unique skill or remedy;

(3) Claims which cannot be readily verified by objective standards; and

(4) Any representation expressly prohibited under KRS 311.597(2).

Section 4. An advertisement may be sent to an individual addressee only if that addressee is one of a class of persons, other than a family to whom it is sent at the same time. An advertisement may not be sent to an addressee if prompted or precipitated by a specific event or occurrence involving or relating to the addressee as distinct from the general public.

Section 5. Violation of any provision of this regulation will be considered dishonorable, unethical or unprofessional conduct of a character likely to deceive, defraud or harm the public or a member thereof pursuant to KRS 311.595(8) and 311.597(2). (11 Ky.R. 1097; Am. 1256; eff. 2-12-85.)

Kentucky's Bluegrass Region Hosts Your 1988 KMA Annual Meeting

Bring your family and explore the many unusual offerings and attractions of Kentucky's Bluegrass region.

Lexington-Fayette County is considered the "heart of the Bluegrass." But the Bluegrass is a multi-county region with names as diverse as the attractions found there.

Versailles, Georgetown and Paris are known for beautiful rolling hills of lush bluegrass and the many fine thoroughbreds stabled there. The emerald green fields are accented by stunning white barns complete with cupolas. Miles of white plank fences flow across the land carefully following the graceful contours of the hills.

A drive through this area takes you past historic sites such as Georgetown's Ward Hall, a covered bridge in Bourbon County and the historic town of Midway.

Midway is a railroad town that looks much the way it did in the 1800s. Small shops filled with antiques and quaint tea rooms line both sides of Railroad Street. Entering the old buildings gives one a sense of discovery. The creak of floorboards and the heavy air that is always present in antique shops is a contrast to the light scent of fresh flowers on the table in the tea rooms.

Central Kentucky has another quaint village of a completely different flavor. Shakertown at Pleasant Hill is a restored community of original Shaker buildings that now house a restaurant, exhibits and craftsmen demonstrating Shaker crafts. The sterile feeling of the white walls and uncluttered simple furnishings exemplify the Shaker philosophies as described by the costumed guides.

The drive from Lexington is a scenic road that winds along the palisades of the Kentucky River. A paddle-wheel riverboat is docked at the Village and offers daily excursions.

Shakertown is part of a historic triangle. Other sites include a reconstructed colonial fort at Harrodsburg, a park and museum where a Civil War battle was fought in Perryville, and Constitution Square in Danville.

Driving out of Lexington to the southeast, you can visit the fort where Daniel Boone settled and the small college town of Berea. *Unusual* is the best way to describe Berea where students must work for the college to pay tuition. The jobs are not the expected work-study positions. Many are employed as weavers, potters and furniture-makers. The famous spoonbread of Boone Tavern Hotel is also served by students.

Government and politics has always been a focal point of Central Kentucky. Senator Henry Clay's home is in Lexington. The State Constitution was framed in Danville and the present State Capital is in Frankfort, just minutes from Lexington.

But the marble halls of state buildings are a sharp contrast to the rustic distilleries of Franklin County. The heavy aroma of fine Kentucky Bourbons fill the air both inside and out of the distilleries.

The area described above requires some driving but you will find that Lexington is a convenient hub city. Making short day-trips from Lexington hotels is a relaxing way to see and do a lot without wearing everyone out.

Located within the city of Lexington are many fine attractions including the following:

AMERICAN SADDLE HORSE MUSEUM — A museum located on the grounds of the Kentucky Horse Park, dedicated to the oldest registered American horse breed — the American Saddle Horse.

ASHLAND, HOME OF HENRY CLAY — The home of statesman Henry Clay, a United States Senator and Speaker of the House of Representatives. This 1811 historic house is filled with family papers, portraits and possessions.

THE BODLEY-BULLOCK HOUSE — Built in 1814, this house served as Union Headquarters under Generals Burbridge and Gilmore during the Civil War.

DUDLEY SQUARE — Historic renovation of 19th century schoolhouse combines charm and elegance in a unique shopping atmosphere. Contains craft shoppes, antiques and Kentucky momentos.

FESTIVAL MARKET — Located in the heart of downtown, Festival Market offers three levels of fun, entertainment, boutiques, cafes and restaurants. A 20-horse carousel on the third level represents the color and traditions of the horse industry.

HEADLEY-WHITNEY MUSEUM — Fine museum of diversified collections, it is the only contemporary collection of its kind open to the public in the United States. The Jeweled Bibelot Collection, Oriental porce-

lains from the Ming Dynasties, a Shell Grotto and the Art Library offer visitors an exciting tour.

HOPEMONT, THE JOHN HUNT-MORGAN HOUSE — Built in 1814 for Kentucky's first millionaire John Wesley Hunt. The Mansion is a Federal masterpiece; cantilevered staircase, formal gardens, walled courtyard and a collection of furniture, portraits and porcelains.

KEENELAND — Popular Thoroughbred race course where the genteel tradition of "racing as it was meant to be," is played out in the Spring and Fall.

KENTUCKY HORSE PARK — Unique in the world, 1,032 acres of exhibits and events, museums and demonstrations and, of course, horses!

LOUDON HOUSE — A Gothic villa which is now the home of the Lexington Art League. The house features a gallery and artist studio tours.

MARY TODD LINCOLN HOUSE — Girlhood home to Mary Todd, Abraham Lincoln's wife. This home is the first shrine to a first lady in America. The house was built in 1803.

THE RED MILE — Historic harness track where trotters and pacers test their speed on the "world's fastest harness track." Spring and Fall racing.

SPENDTHRIFT — Tour the world famous horse farm, Training Center and watch Thoroughbreds work out on the covered track. See the award-winning multi-media presentation, "To Race the Wind."

TRANSYLVANIA UNIVERSITY — Oldest institution of higher learning in the West features Old Morrison Hall, a classic Greek Revival style building that is a national historic landmark.

TRIANGLE PARK — Favorite downtown gathering spot for "Lunch with the Arts," or a midnight stroll. Unique water steps are the focal point for this tree-lined park, built through the generosity of private citizens.

UNIVERSITY OF KENTUCKY — With an enrollment of 21,000 the University of Kentucky has a national and international reputation in such diverse fields as medicine, sociology, political science, equine research and agriculture.

VICTORIAN SQUARE — A complete renovation of a downtown city block brought back to its former splendor so that today its elegant facade hosts the finest in retail shops and restaurants.

Come to your Annual Meeting prepared not only to study and learn but to tour, to relax, and to enjoy this beautiful region of our state.



September 3-5
Fourth Annual Multispecialty Oculoplastic Surgery Symposium,
Lexington Marriott Resort, Lexington, KY. Contact: Jennifer DePrima Richard, Ophthalmology Center, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509, (606) 268-3754.

October 12-13
Care of the Seriously Ill Child —
The 16th Annual Fall Pediatric Surgery/ Pediatrics Symposium concerning "Acute Pediatric Emergencies", Lincoln Hotel and University Conference Center, Indianapolis, IN. Sponsored by the Indiana University School of Medicine. Contact: Jay L. Grosfeld, MD, (Symposium Director) Surgeon-in-Chief, Riley Hospital, 702 Barnhill Dr, Indianapolis, IN 46223, (317) 274-8353.

October 27
Health Fraud Conference,
Campbell House, Lexington, KY. Sponsors include the University of Kentucky Cooperative Extension Service, Kentucky Dietetic Association, University of Kentucky School of Nursing and the Attorney General's Health Fraud Task Force. Contact: Darlene Forester, PhD, RD, University of Kentucky, 120 Erikson Hall, Lexington, KY 40506, (606) 257-1812.

December 7-9
American Cancer Society, National Conference on Advances in Cancer Management,
Hyatt Regency Hotel, Los Angeles, California. Contact: American Cancer Society, National Conference on Advances in Cancer Management, 3340 Peachtree Rd, NE, Atlanta, GA 30026. (212) 599-3600.

Fourth Annual Multispecialty Oculoplastic Surgery Symposium

September 3-5, 1988
Lexington Marriott Resort
Lexington, Kentucky

Symposium Director
William N. Offutt, IV, M.D.

Co-Director
John W. Collins, M.D.

Special Guest Lecturers
Herbert E. Kaufman, M.D.
New Orleans, LA
Byron C. Smith, M.D.
New York, NY

Faculty By Specialty

Ophthalmologists
Joseph F. Arterberry, M.D. Louisville, KY
Robert S. Baker, M.D. Lexington, KY
Howard L. Beale, M.D. Memphis, TN
Thomas H. Casanova, III, M.D. Crowley, LA
Douglas G. Day, M.D. Lexington, KY
Robert M. Dryden, M.D. Tucson, AZ
John W. Garden, M.D. Lexington, KY
Douglas Gossman, M.D. Louisville, KY
Rick D. Isernhagen, M.D. Lexington, KY
Robert C. Kersten, M.D. Cincinnati, OH
Bruce H. Koffler, M.D. Lexington, KY
Fay E. Millett, M.D. El Paso, TX
Earl L. Nelson, M.D. New Orleans, LA
James G. Pope, M.D. Lexington, KY
Arthur J. Schaefer, M.D. Buffalo, NY
J. Howard Stokes, M.D. Florence, SC
Woodford S. Van Meter, M.D. Lexington, KY
Ralph E. Wesley, M.D. Nashville, TN
Eugene O. Wiggs, M.D. Denver, CO
Darrell E. Wolfley, M.D. New Orleans, LA
William J. Wood, M.D. Lexington, KY

Plastic Surgeons
Raleigh R. Archer, M.D. Lexington, KY
Phillip K. Blevins, M.D. Lexington, KY
William L. Dowden, M.D. Lexington, KY
Ivo Pitanguy, M.D. Rio de Janeiro, Brazil
Henry C. Vasconez, M.D. Lexington, KY

Oral Surgeons
Arthur A. Gonty, D.D.S. Lexington, KY
Markell W. Kohn, D.D.S. Lexington, KY
Len W. Morrow, D.M.D. Lexington, KY

Ophthalmic Pathologist
Richard A. Kielar, M.D. Lexington, KY

Dermatologists
Joseph P. Bark, M.D. Lexington, KY
Joseph W. Buecker, M.D. Louisville, KY

Otolaryngologists
Ferdinand F. Becker, M.D. Vero Beach, FL
Calvin M. Johnson, M.D. New Orleans, LA
S. Randolph Waldman, M.D. Lexington, KY
Robert D. Woods, II, M.D. Lexington, KY

Ocularist
Bruce Cook, C.O. St. Louis, MO

- A conjoint symposium by all specialties involved with the management of problems of the midface and ocular adnexa.
- State of the art solutions to the difficult situations in the realm of oculoplastic surgery.

Registration
Physicians: - $350 Residents: - $100

Accreditation
12 Hours AMA/CME

Recreational Opportunities
- Dove hunting
- Tour of Bluegrass thoroughbred horse farms
- Iroquois Hunt Club dinner
- Swimming, golf, tennis, health club facilities, whirlpool and saunas available for the Marriott Resort guests.

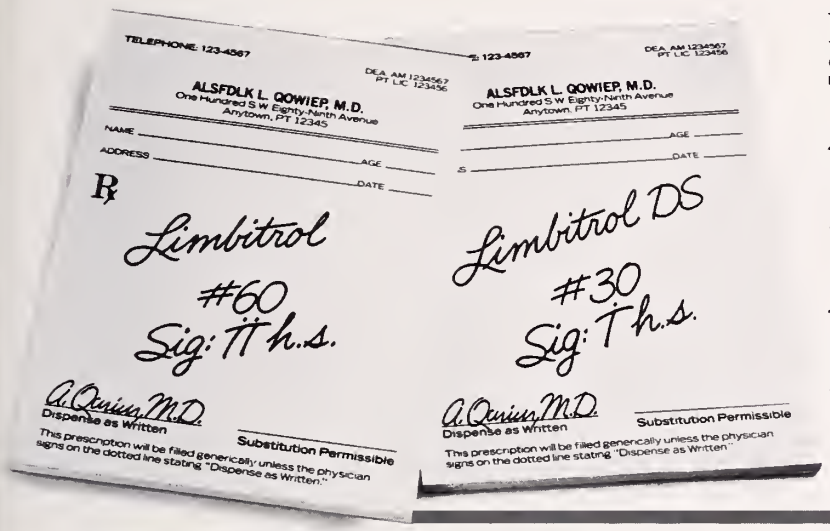
Optional Course
CooperVision will sponsor a Phacoemulsification/Small Incision Course for general ophthalmologists on September 2. Fee: $150

Information
Jennifer De Prima Richard
Conference Coordinator
Ophthalmology Center
Humana Hospital - Lexington
150 North Eagle Creek Drive
Lexington, Kentucky 40509
(606) 268-3754

THE OPHTHALMOLOGY CENTER OF EXCELLENCE
Humana Hospital – Lexington

In moderate depression and anxiety

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week improvement in somatic symptoms[1]
- 50% greater improvement with Limbitrol in the first week than with amitriptyline alone[2]



Protect Your Prescribing Decision: Specify "Do not substitute."

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓥ

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓥ

References: **1.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

Limbitrol®Ⓥ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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ROCHE PRODUCTS INC.
Manati, Puerto Rico 00701

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In the depressed and anxious patient

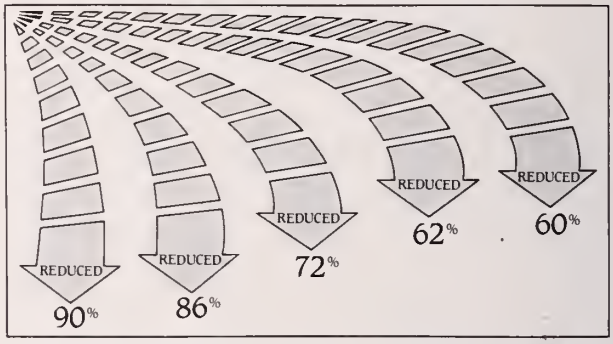
See Improvement In The First Week...[1]

And The Weeks That Follow

- 74% of patients experienced improved sleep after the first *h.s.* dose[1]
- First-week reduction in somatic symptoms[1]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

Limbitrol®

Each tablet contains 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt) Ⓒ IV

Limbitrol® DS

Each tablet contains 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt) Ⓒ IV

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What's new in Cancer Therapy

KMA 1988 Annual Meeting
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Hyatt Regency Lexington/Lexington Center
Lexington, Kentucky

Annual Meeting Program Page 449

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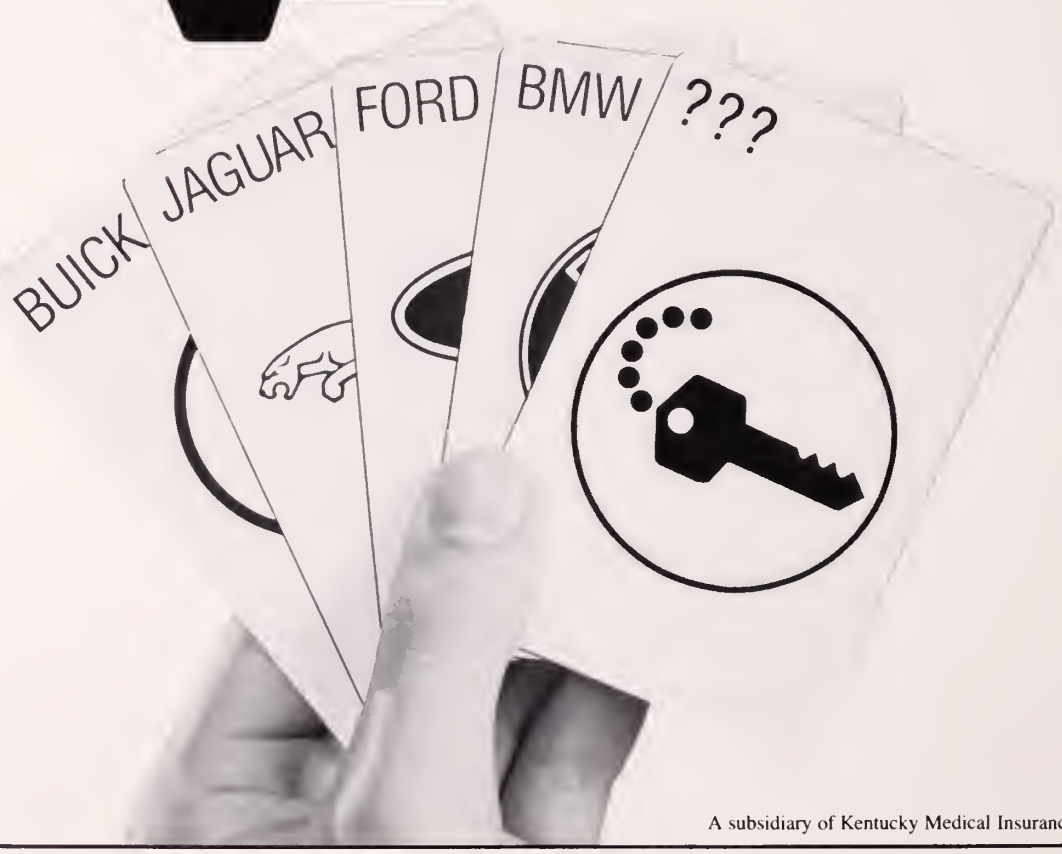
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TABLE OF

CONTENTS

August 1988

Cover:
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SCIENTIFIC

Endoscopic Nd:YAG Laser Therapy for Advanced Esophageal Cancer
Sang Seol Jung, MD; T. Jeffery Wieman, MD **405**

Adenocarcinoma in Exstrophy and Defunctional Ureterosigmoidostomy
Ramachandra M. Krishnamsetty, MD; Mohan K. Rao, MD; Cynthia R. Hines, MD; Elie P. Saikaly, MD; Roberto P. Corpus, MD; Harry O. DeBandi, MD **409**

Childhood Cancer Clinical Trials and Regional Tumor Registries
Salvatore J. Betolone, MD, FAAP; Pamela Scott, MSN, BSN **415**

EDITORIAL

For the Love **421**

ASSOCIATION

1988 Annual Meeting Section **431**
Scientific Program **449**
General Sessions Summaries **461**
1988 Technical Exhibitors **467**

REGULAR FEATURES

President's Page **401**
Auxiliary **427**
Letters to the Editor **425**
CME **485**
Classified **483**
Information for Authors **408**

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AUGUST 1988

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August Buyer's Guide

Charleston Area Medical Center....403, 424
Classified 483
Elcomp Systems, Inc. 422
Insurance Corporation of America 418, 419
KMA Insurance Agency, Inc. 398, 428
KMIC 404
KMIC Leasing Company 394
Kentucky Air National Guard 480
Key Pharmaceuticals 481, 482
Eli Lilly & Company 430
Medical Protective Company 423
Miles Pharmaceuticals 399, 400
Naval Reserve Force 482
PIE Mutual Insurance Company 426
Roche Laboratories 487, 488
Signature, Inc. 480
Skycare, Inc. 420
U.S. Air Force 420
U.S. Army Reserve....402, 429

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(ciprofloxacin HCl/Miles)

A REVOLUTIONARY ORAL ANTIMICROBIAL WITH THE POWER OF PARENTERALS

- **Highly active *in vitro* against a broad range of gram-positive and gram-negative pathogens, including methicillin-resistant *Staphylococcus aureus* and *Pseudomonas aeruginosa****
- **For treatment of infections in the:**
  - **lower respiratory tract†**
  - **urinary tract†**
  - **skin/skin structure†**
  - **bones and joints†**
- **Convenient *B.I.D.* dosage – 250 mg, 500 mg and 750 mg tablets**

**In vitro* activity does not necessarily imply a correlation with *in vivo* results.

†**Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

CIPRO® SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN.

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

MILES

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Pharmaceutical Division
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West Haven, CT 06516

Please see adjacent page of this advertisement for Brief Summary of Prescribing Information.

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C09327 MLR-261

Cipro® TABLETS
(ciprofloxacin HCl/Miles)

■ 500 mg *B.I.D.* for most infections;
750 mg *B.I.D.* for severe or complicated infections.

BRIEF SUMMARY
CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION

INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below

Lower Respiratory Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Pseudomonas aeruginosa, Haemophilus influenzae, Haemophilus parainfluenzae,* and *Streptococcus pneumoniae*

Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes.*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri;** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin Therapy with Cipro® may be initiated before results of these tests are known, once results become available appropriate therapy should be continued As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN The oral administration of ciprofloxacin caused lameness in immature dogs Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION)

PRECAUTIONS

General.

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS)

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided The recommended daily dose should not be exceeded Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION)

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life This may result in increased risk of theophylline-related adverse reactions If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired, concurrent administration of these agents with ciprofloxacin should be avoided

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms Repeated evaluation of the patient's condition and microbial susceptibility testing is essential If superinfection occurs during therapy, appropriate measures should be taken

Information for Patients.

Patients should be advised that ciprofloxacin may be taken with or without meals The preferred time of dosing is two hours after a meal Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing Ciprofloxacin may cause dizziness or lightheadedness, therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducteu with ciprofloxacin and the test results are listed below

- Salmonella/Microsome Test (Negative)
- *E coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed

Pregnancy – Pregnancy Category C

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion No teratogenicity was observed at either dose After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed There are, however, no adequate and well-controlled studies in pregnant women SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS)

Nursing Mothers.

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated During clinical investigation, 2,799 patients received 2,868 courses of the drug Adverse events that were considered likely to be drug related occurred in 7 3% of courses, possibly related in 9 2%, and remotely related in 3.0% Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1 5%), skin (0 6%), and central nervous system (0 4%)

The most frequently reported events, drug related or not, were nausea (5 2%), diarrhea (2 3%), vomiting (2 0%), abdominal pain/discomfort (1 7%), headache (1 2%), restlessness (1 1%), and rash (1 1%)

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below Those typical of quinolones are italicized

GASTROINTESTINAL *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia*

SKIN/HYPERSENSITIVITY *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum

SPECIAL SENSES: *blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste*

MUSCULOSKELETAL *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout

RENAL/UROGENITAL *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin

Adverse Laboratory Changes Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic – Elevations of ALT (SGPT) (1 9%), AST (SGOT) (1 7%), alkaline phosphatase (0 8%), LDH (0 4%), serum bilirubin (0 3%)

Hematologic – eosinophilia (0 6%), leukopenia (0 4%), decreased blood platelets (0 1%), elevated blood platelets (0 1%), pancytopenia (0 1%)

Renal – Elevations of Serum creatinine (1 1%), BUN (0 9%)

CRYSTALLURIA, CYLINORURIA, AND HEMATURIA HAVE BEEN REPORTED

Other changes occurring in less than 0 1% of courses were Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis

OVERDOSAGE

Information on overdosage in humans is not available In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage The patient should be carefully observed and given supportive treatment Adequate hydration must be maintained In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours

The recommended dosage for infectious diarrhea is 500 mg every 12 hours

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION)

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"The hospitals are taking over the practice of medicine."

"Managed health care really means pay doctors lower fees and tell them how to do as little as possible as fast as possible."

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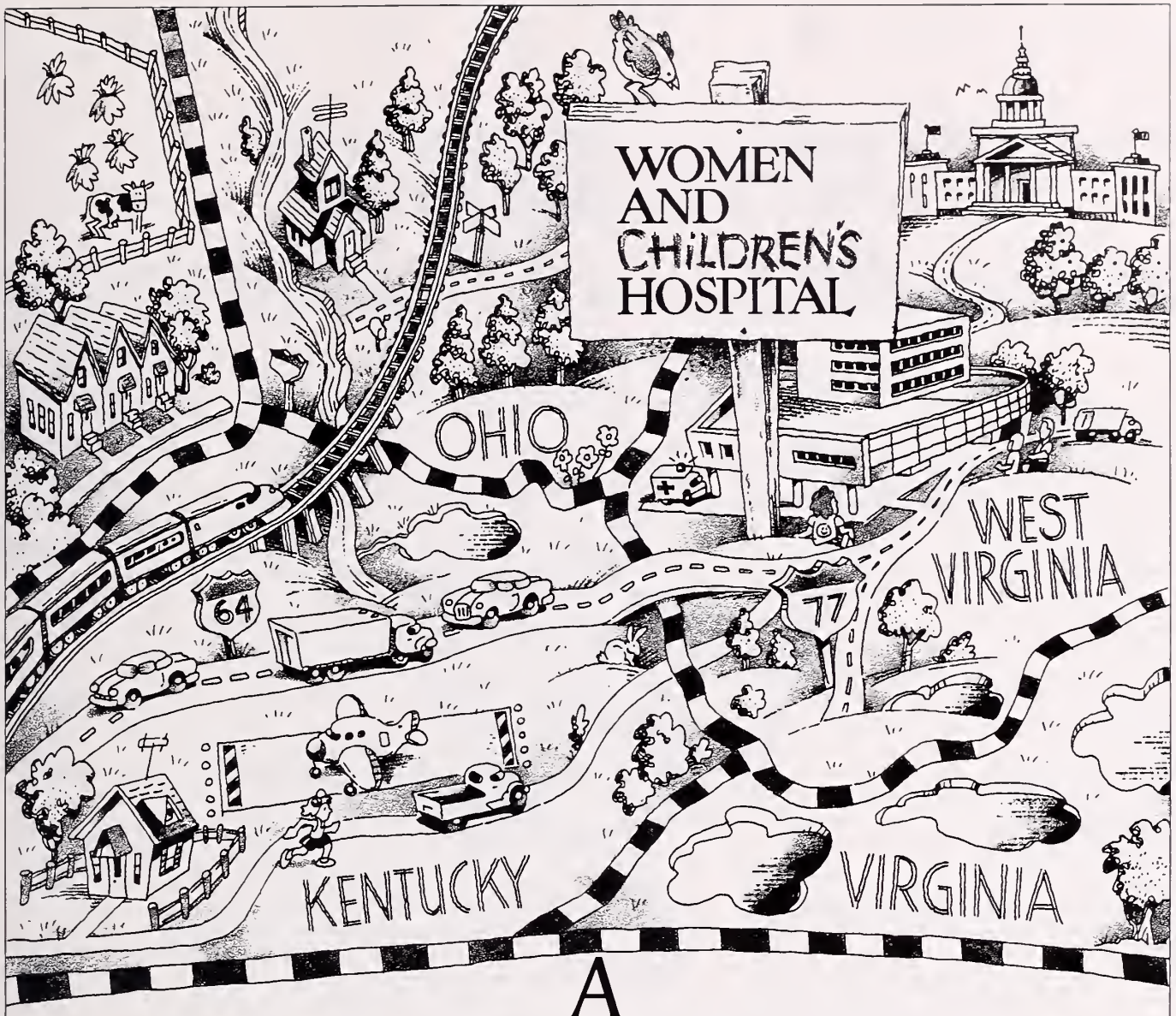
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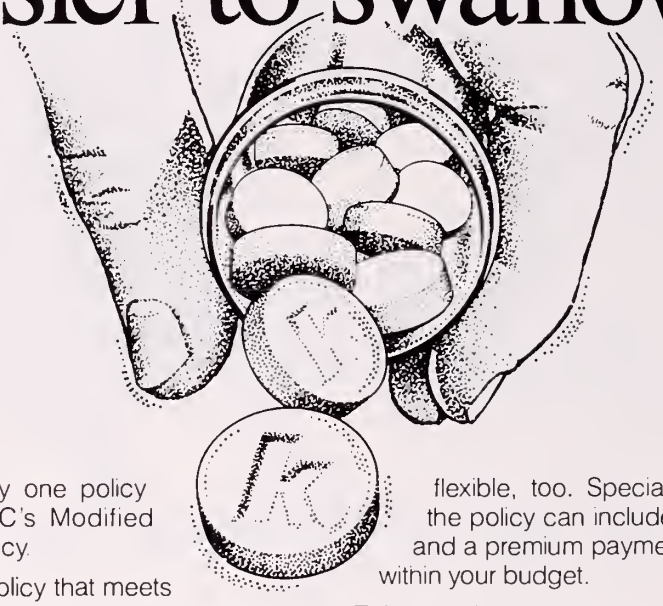
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Endoscopic Nd:YAG Laser Therapy for Advanced Esophageal Cancer

From the Department of Surgery, University of Louisville School of Medicine. Reprint requests to Department of Surgery, University of Louisville, Division of Surgical Oncology, James Graham Brown Cancer Center, 529 South Jackson Street, Louisville, KY 40292. (Dr Wieman).

Sang Seol Jung, MD
T. Jeffery Wieman, MD

This report presents our experience in treating 16 patients with obstructing esophageal cancer using the Nd:YAG Laser at the University of Louisville affiliated hospitals. All patients had dysphagia on admission and most were able only to consume liquids. Esophageal obstructions ranged from 50% to 100% of luminal diameter judged endoscopically or radiologically. The tumors were felt to be unsuitable for resection by a member of the Department of Surgery. Average laser power output was 43 watts and total energy deposited during each treatment was 6,500 joules. Mean length of hospital stay was one day. Half of the patients were treated without admission. An average of 2.5 sessions per patient were needed to maintain patency for the duration of the patient's lifetime. No major complications were associated with the procedures. Survival averaged 5.8 months. All but one patient could eat solid or soft food within 24 hours after treatment. Considering the quality of life after treatment, the use of the Nd:YAG laser for management of obstructing esophageal cancers is a reasonable therapeutic alternative in patients who are not candidates for operative resection.

Esophageal cancer is not a rare disease in the United States; however, because this tumor is usually asymptomatic until it reaches an advanced state, only about 5% of patients with this disease are cured.[1] Since the cure rate is low and symptoms which develop are severely disabling, a large number of palliative management strategies have been advocated, including a variety of therapeutic fiberoptic endoscopic procedures.[2-4] One of the most recently introduced modalities has been the adaptation of the laser for endoscopic use. Lasers are employed as thermal instruments to coagulate and vaporize tumors which are obstructing the esophageal lumina. Although a variety of lasers have been used to treat cancers, the Nd:YAG laser is the most successful and widely applied device because its light penetrates deeply into tissues. The Nd:YAG laser is also highly transmissible through quartz fiber, making it practical for use through flexible endoscopes.[5] The authors have summarized information on the first 16 patients with esophageal cancer treated by Nd:YAG laser at University Hospital from January 1986 to July 1987.

Patients and Methods

All patients offered this treatment had been assessed as unsuitable for surgical resection by a member of the Department of Surgery at the University of Louisville. Each patient underwent a pretreatment endoscopic examination with biopsy to confirm diagnosis and evaluate the status of the disease. The following information was abstracted for each patient: age, sex, histology and location of tumor, extent of tumor involvement, and percent of obstruction. For therapeutic consideration, power output, total energy deposition per treatment, and time interval between treatment were included. Symptomatic relief and quality of life after treatment were evaluated by Karnofsky Performance Status,[6] complications, and survival (Table 1).

Endoscopic laser treatment was administered using Nd:YAG laser (Lasersonics Model 8,000, Cooper Inc, California, USA). The laser energy was transmitted through a 600 um quartz fiber passed through the biopsy channel of a flexible fiberoptic endoscope (Olympus GIF-IT, Olympus Corporation of America, New Hyde Park, NY, USA). Patients were placed in the left lateral decubitus position. Anesthesia was achieved using Cetacaine@ (benzocaine 14%, tetracaine hydrochloride 2%) spray. After insertion of the fiberscope to the level of the inferior margin of the lesion, treatment began from the luminal margin, which was used as an anatomical landmark. By starting the ablation at the inferior margin of the tumor more visibility can be maintained throughout the procedure. If it is not possible to pass the endoscope through the strictured tumor, dilation should be performed before beginning the laser procedure. On occasion, the strictured segment is short or dilation is not possible. In these cases, destruction of the tumor should be initiated from the superior margin of the tumor. This is a slower and more risky approach, however. Coagulation and vaporization are alternated to maintain hemostasis while destroying the tumor. Maintenance of hemostasis is important because blood both obscures the field of view and absorbs the light energy, making progress slow and increasing the risk of an inadvertent perforation. The fiber tip is held 1 cm from the tumor, emitting 30 to 50 watt pulses lasting from one to three seconds.

Table 1

Clinical and Endoscopical Characteristics

Patient No.	Age (year)	Tumor Location (cm)	Tumor Length (cm)	Luminal Occlusion (%)	No. of Tx.	Karnofsky Scale (% changes)	Survival (months)
1.	57	20—26	6	50	1	100	4
2.	62	29—39	10	100	1	100	5
3.	73	35—39	4	100	1	50	3
4.	74	30—35	5	90	1	100	4
5.	72	35—39	4	100	3	300	8
6.	61	20—32	12	95	7	100	18
7.	59	30—37	7	60	2	166	4
8.	67	25—29	4	90	1	100	1
9.	65	24—34	10	50	3	100	7
10.	60	30—39	9	100	1	50	0.1
11.	73	20—28	8	95	7	166	20
12.	81	18—28	10	100	3	125	3
13.	56	33—38	5	95	2	133	5
14.	45	35—39	4	80	1	133	3
15.	88	25—30	5	70	3	80	12
16.	66	28—35	7	100	3	100	4

Coaxial air flow is used to protect the laser fiber tip and tumor debris is removed using biopsy forceps.

The patients were usually permitted to go home as soon as they were alert. Liquid diets were allowed four hours later, and a normal diet was resumed within 24 hours after treatment. An attempt was made to complete the treatment in a single session, lasting about one hour. If it was not possible to complete ablation of the tumor within that period, the patient was retreated one week later, allowing time for necrotic tumor to slough.

Results

Thirteen male and three female patients were treated. Mean patient age was 66 years, with ages ranging from 45 to 88 years. Thirteen patients had squamous cell cancer and three patients had adenocarcinoma. Average length of tumor involvement was 7 cm, with a range of 4 to 12 cm. Six patients had total luminal occlusion and none had less than 50% obstruction (Table 1). An average of 6,500 joules were delivered in each session. Full luminal patency was achieved in a mean 2.5 sessions. Nine patients have undergone repeated treatments, which ranged from two to seven procedures. Each procedure kept the patients free from obstruction for at least one month. One-half of the patients were treated on an outpatient basis and the others required admission for one to three days. Therapeutic response was evaluated by Karnofsky Performance Status (KPS). The mean change in KPS was a 133% improvement, from 30 pretreatment to 70 post-treatment. No mediastinal perforations occurred. One tracheoesophageal fistula, which is thought to have been caused by tumor progression, developed three weeks after treatment. One episode of bleeding occurred a week after the procedure but stopped spontaneously. A transient low grade fever (100°F) occurred in three patients and one patient reported epigastric pain. Mean survival was 5.8 months, and at the present time two of the patients are alive 22 and 18 months after initial treatment. None of the patients were able to tolerate soft diet before treatment regardless of the extent of obstruction. All but two were able to eat a normal diet after treatment. Of the two patients with poor results, one suffered from chronic obstructive pulmonary disease and died of respiratory failure three days post-treatment, and one had a tumor located on the cricopharyngeal region of the proximal esophagus.

Discussion

The dismal five-year survival rate for esophageal cancer remains poor in spite of a variety of aggressive attempts at treatment.[7] Poor survival is the result of both failure to diagnose these lesions sufficiently early to permit cure and inadequacies of the therapeutic methods available. For this reason, palliative treatment is commonly employed for esophageal cancer. Currently, useful methods of palliation include surgery, radiation, bougiennage, prosthetic stents, gastrostomy and pharyngostomy, and chemotherapy. In a critical review of surgery for esophageal cancer by Earlam and Cunha-Malo,[1] out of 100 patients, 58 were explored, 39 resected, 26 left the hospital with tumor excised, 18 survived for one year, nine for two years. Only four patients survived for five years. There have been no controlled trials between radiotherapy and surgery, but survival rates of irradiated patients appear to be quite similar: 18% for one year, 8% for two years, and 6% for five years.[8] Unfortunately, radiation takes several weeks to provide symptomatic relief and it cannot be reemployed after recurrence. The side effects of nausea and ill-feeling are additional problems in these debilitated patients.[8]

Gastrostomy or pharyngostomy deprive the patient of the capacity to eat and do not really solve the difficulty of aspiration. Even though a number of encouraging results with chemotherapeutic combinations have been reported,[9,10] remissions are few, and the survival rate is very low.

Lasers have been used in the gastrointestinal tract since 1976, when Dwyer[11] and colleagues first used an argon laser to control gastrointestinal bleeding. After that time, the argon laser has been replaced by Nd:YAG laser for use in the gastrointestinal tract for the control of bleeding and destruction of tumors. Fleisher,[12,13] who first described the use of lasers in esophageal cancer, recommends a sequential technique whereby the proximal portion of the tumor is lasered, followed by sequential treatments, which progressively burrow through the tumor mass. Recently, a single session method successfully accomplished tumor treatment using esophageal dilation prior to using the laser.[14] Single session treatment is more cost effective than sequential treatment, and it does not compromise safety or effectiveness. Patience and accurate imaging by the operator are essential to achieve the best result in laser treatment. In our series, dilation was occasionally needed between laser treatments. This must be done with great care since perforation of the esophagus is frequently a fatal complication.

The immediate relief of dysphagia with subsequent improvement in the status of patients should provide a better tolerance for irradiation and better survival in combination with post-laser radiation. Most of the patients had weight gain after the obstruction was relieved, including one man who gained 25 pounds in three weeks after he resumed a normal diet. Even the most weak and debilitated patients can be treated. One 88-year-old patient survived for 12 months with three sessions of laser treatment. Low incidence of complications and the feasibility of retreatment are very real advantages in such cases.

Tumors of the cervical esophagus are the most difficult to treat because of limited space for manipulation. Thus, the location of tumor, rather than the extent of luminal occlusion or length of tumor involvement, is an important factor influencing the therapeutic performance. In addition to anatomical problems, tumors of the cervical esophagus affect the swallowing mechanism itself, and even when luminal patency has been satisfactorily restored dysphagia may not be totally relieved. However, all patients are able to handle saliva and liquids.

Summary

Nd:YAG laser provides a relatively simple and highly effective means of palliation for patients with obstructing esophageal carcinomas, allowing them to eat a regular diet and spend the rest of their usually short lives outside a hospital. Considering the quality of life after treatment, the use of the Nd:YAG laser for management of obstructing esophageal cancers, alone or in combination with radiation and chemotherapy, is a reasonable therapeutic alternative in patients who are not candidates for operative resection.

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Adenocarcinoma in Exstrophy and Defunctional Ureterosigmoidostomy

From the Merle M. Mahr Cancer Center/Trover Clinic, Madisonville, KY. Reprint requests to: Merle M. Mahr Cancer Center, Regional Medical Center, Madisonville, Kentucky 42431 (Dr Krishnamsetty).

Note: Review of literature current up to November 1987.

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World literature reveals 104 cases of malignancies in untreated exstrophy of the bladder and 89 cases of malignancies in exstrophy of the bladder which were treated with ureterosigmoidostomy. We report here the 90th case of carcinogenesis in exstrophy of the bladder treated in childhood with staged ureterosigmoidostomy and cystectomy, followed by defunctionalization of the ureterosigmoidostomy four years later. When the patient was in her twenties, adenocarcinoma developed in the rectosigmoid. There is a high risk of malignancy in treated or untreated exstrophy of the bladder. It has been known for sometime that ureterosigmoidostomy per se, done for bladder exstrophy or otherwise, carries a risk of colon cancer 7,000 times that of general population age 25 years or under. Rediversion does not negate carcinogenic effects of ureterosigmoidostomy once existed. We recommend hospital, state and/or national level review of all past ureterosigmoidostomy cases and formation of a registry with the intent of informing the patients of risks involved.

Introduction

Exstrophy of the bladder is a rare congenital anomaly occurring about once in every 50,000 births. Classic exstrophy and cloacal exstrophy are developmental abnormalities resulting from perforation of the abnormal cloacal membrane.[1] The abnormal development of the cloacal membrane results in a spectrum of conditions that vary in severity.[1] Bladder exstrophy accounts for more than 50% of the patients in the spectrum.[1] It is widely noted in the literature that Bergenhem reported the first case of adenocarcinoma in untreated exstrophy of the bladder in 1895; Simon described the first urologic procedure for ureterosigmoidostomy in 1852; and Hammer reported on a case of adenocarcinoma at the site of ureterosigmoidal anastomosis in 1929. Since those early reports, there have been several other reports. Our case is unusual in that it is one of very few in the literature where an adenocarcinoma developed at the site of ureterosigmoidostomy which was functional for only four years but remained defunctionalized for sixteen years prior to developing malignancy. We have reviewed the world literature and tabulated the summary.

Case Report

Our patient is a female born with exstrophy of the bladder. At the age of 1 year, she was referred to a children's hospital in the region and, initially, recurrent rectal prolapse was successfully managed by retrorectal nitrofurazone (Furacin) packing to cause scarring.

At the age of 2 years, she underwent ureterosigmoidostomy. At the age of 4 years, she underwent cystectomy. The specimen of the urinary bladder measured 4x4x1 cm. The bladder wall was very nodular with individual nodules up to 1 cm in diameter. The patient's care was then transferred to the local county hospital.

In the intervening years, she experienced several episodes of hyperchloremic acidosis, developed left hydronephrosis and hydroureter, and had episodes of mechanical small bowel obstruction requiring lysis of adhesions and decompressive enterostomy.

At the age of 6 years, she underwent hymenotomy and vaginoscopy and bimanual palpation through the rectum under anesthesia which showed the pelvic organs to be essentially normal. One month later, she underwent ureteroileostomy at which time the ureters were located where there had been anastomosis to the proximal end of the sigmoid colon and were clamped and diverted and the stump near the sigmoid was ligated. The ureters were anastomosed into the ileal conduit. The blood urea nitrogen returned to normal postoperatively and the hyperchloremic acidosis cleared. Following that, the patient did not experience any major medical problems and was lost to follow-up and was infrequently seen by any physician. At the age of 14 years, litholapaxy of a large calculus in the ileostomy pouch and revision of the ileostomy stoma was performed. A year later, she underwent a left nephrolithotomy. In the following years, she experienced several episodes of pyelonephritis.

At the age of 22, while pursuing a radio communications career, she presented to the Regional Medical Center of Hopkins County, Kentucky with abdominal pain and bloating of three to four weeks' duration. An exploratory laparatomy revealed a rectal stricture. Full thickness rectal biopsies revealed signet ring cell ade-

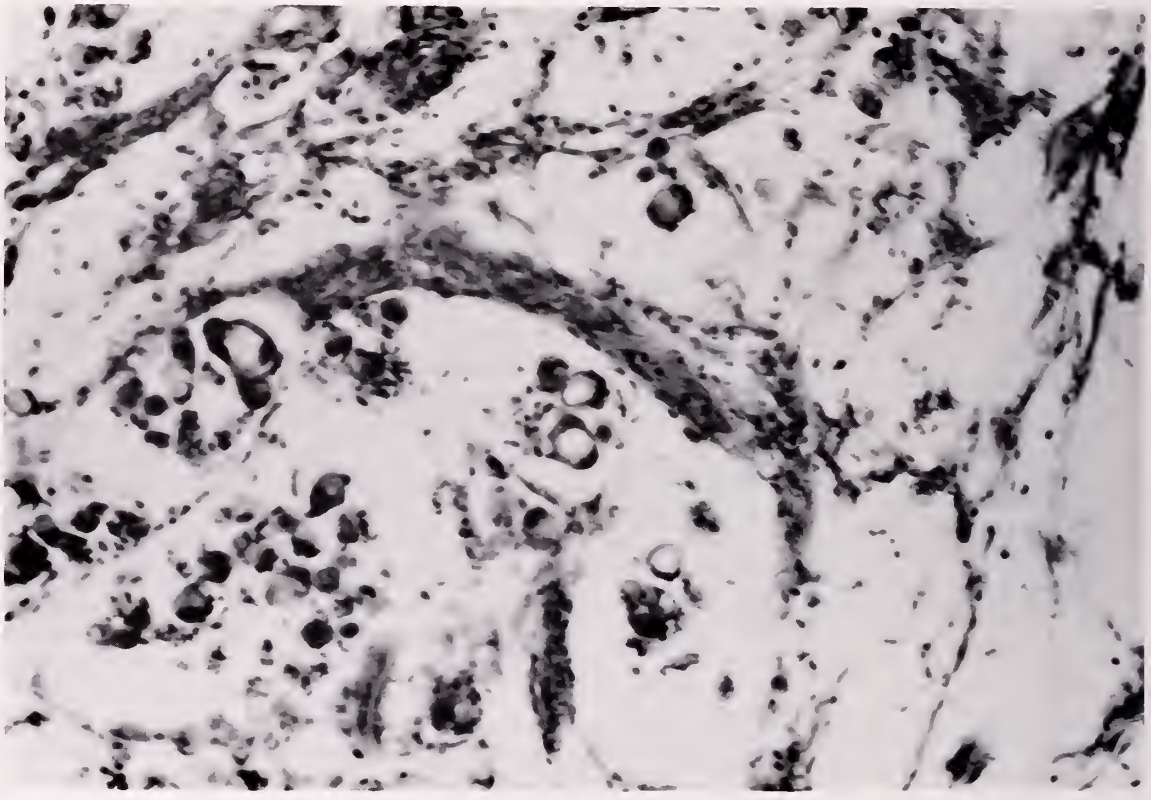


Fig 1 — Rectal wall with "signet-ring" adenocarcinoma (hematoxylin-eosin, x 40)

nocarcinoma of the rectum. She then underwent pelvic exenteration and revision of the ileal conduit. The pathology specimen which contained distal colon, rectum, anus with attached uterus, two tubes and two ovaries revealed signet ring cell adenocarcinoma (Fig 1) of the rectum, infiltrating and extending to surrounding periectal connective tissue and the regional lymph nodes (11 out of 16 were positive).

Postoperatively, she developed necrotizing fascitis of the anterior abdominal wall and small bowel fistula, as well as colon fistula in the midline, and many types of therapies were tried which lasted for six months. She received one course of doxorubicin (Adriamycin), 5-Fluorouracil (5FU) and cis-platinum chemotherapy and refused any further chemotherapy.

Nine months from diagnosis, a perineal biopsy was positive for recurrent signet ring cell carcinoma, and she received external radiation therapy to the pelvis and the perineum in a dose of 4,500 cGy over 37 elapsed days in 25 fractions of 180 cGy were given with the AP and PA ports using 6MV x-rays.

Shortly thereafter, she developed mechanical small bowel obstruction and at surgery was found to have tumor deposits in the abdominal wall on the right side and the biopsies were positive for recurrent signet ring cell carcinoma. There was extensive abdominal carcinomatosis. Postoperatively, she had several episodes of dehydration and hyperkalemia and received palliative treatment to maintain her nutritional status and fluid and electrolyte balance. She continued a downhill course and expired shortly after her 24th birthday, 14 months after diagnosis. An autopsy was not performed.

Review of World Literature

We did a complete review of the world literature by using the computer search on Medline and Cancerlit. Since 1951, several authors have compiled the previous case reports from the literature, including their own, and the reported incidence of neoplasms in relation to treated or untreated bladder exstrophy and also neoplasms associated with ureterosigmoidostomy done for

TABLE 1

Selected World Literature Reviews on Neoplasms in Bladder Exstrophy and Ureterosigmoidostomy (USO)*

Author:	Goyanna et al	Urdaneta et al	O'Kane and Megaw	Mueller and Thornbury	Kandzari et al	Lasser and Acosta
Ref. No.:	2	3	4	5	6	7
Year of Publication:	1951	1966	1968	1973	1974	1975
Malignancies in Bladder Exstrophy	7†		56		57	
Adenocarcinomas in Bladder Exstrophy (Untreated)			47		47	
Colonic Neoplasms at or near USO site done for any condition:§						
All		16		14		31
Benign		3		1		10
Malignant—		13		13		21
Adenoca		6		8		14
Other		7		5		7
Colonic Neoplasms at or near USO site done for Bladder Exstrophy:						
All		5		5		17
Benign		1		0		6
Malignant—		4		5		11
Adenoca				2		7
Other		4		3		4

Allen	Eraklis and Folkman	Spence et al	Dube et al	Charron and Delisle	Ponce Socorro et al	Nielsen and Nielsen	Harzmann et al	Krishnamsetty et al
8	9	10	11	12	13	14	15	
1977	1978	1979	1979	1982	1983	1983	1984	Present
59					78	81	97‡	104
50						68		
		55	42	48			73	90
			10	12				
			32	36				
			20	33				
			12	3				
		35	26	33				
		7	6	9				
		28	20	24				
	17	24						
		4						

* Patient numbers of each later author includes the case count of previous reviews and the intervening case count and their own case reports.
† Out of 170 cases of exstrophy of bladder at Mayo Clinic only.
‡ Includes cases treated with bladder closure.
§ Including bladder exstrophy.

TABLE II

Case Count in Literature of Malignancies in Bladder Exstrophy

Author	Year	Ref.	Bladder Exstrophy Untreated Or Treated With Closure	Treated With Cystectomy and Ureterosigmoidostomy
Harzmann et al*	1984	15	97†	73‡
Cipolla et al	1984	16		1§
Steg et al‖	1985	17		1§
Beynon et al	1986	18	1§	
Zvara et al	1986	19		2§
Ibrahim et al	1986	20		1§
Gharib et al	1986	21		1§
Zabbo et al	1986	22	4¶**	6¶††
				4¶‡‡
De Riese et al	1986	23	1§	
Facchini	1987	24	1§	
Krishnamsetty et al	Present			1§
Total in Literature:			104	90

* Review of Literature from Hammer's first case in 1929 to 1984.
† Adenocarcinoma 93%, Squamous Cell Carcinoma 3%, Undifferentiated 2%, Urothelioma or Rhabdomyosarcoma 1%
‡ Adenocarcinoma 90%, Urothelioma 10%
†‡ There is a slight discrepancy in the figures reported in the author's German text and author provided English abstract.
§ Adenocarcinoma
‖ Reported two other cases not relevant for this title.
¶ Histology not cited.
** Bladder ca.
†† Dead at report.
‡‡ Alive at report.

bladder exstrophy and conditions other than bladder exstrophy (Table I). To our knowledge, Harzmann[15] has done the most recent review of literature on the subject, in 1984, and it has been published in the German language. We have reviewed all case reports on the subject since then and have updated the total case count (Table II).[15,24] One should note that there is a minor variation in the case count of preceding and succeeding authors, reflecting the problems associated with the lack of a unified registry of these cases. The shortest age of ureterosigmoidostomy in the literature is nine months which resulted in the development of adenocarcinoma 14 years after rediversion or defunctionalization.[10] Even though adenocarcinoma is the most predominant form of malignancy, other malignancies such as squamous cell carcinoma, undifferentiated carcinoma, and rhabdomyosarcoma are also known.

Pathogenesis

Several hypotheses exist for the carcinogenesis in exstrophied bladder: 1. Chronic infection and constant mechanical irritation of the transitional cell epithelium of the exposed bladder.[25] 2. Because the bladder and rectum originate from the common embryological structure, that is cloaca, the epithelial lining of the bladder undergoes reversionary cataplasia resulting in formation of mucoid columnar cells.[25] 3. Also, because of common embryologic origin, the mucosa of the rectum contains epithelium of the vesical type in patients with exstrophy of the bladder which is exposed to the irritation of the rectal contents.[25]

For the carcinogenesis at the site of ureterosigmoidostomy, several hypotheses exist. From clinical and experimental observations, Gittes has shown that the carcinogenesis of ureterosigmoid-

ostomy clearly depends on the initial presence of urine, feces, urothelium and colonic epithelium in close apposition at the healing anastomotic suture line.[26] One plausible hypothesis is the conversion of the urinary precarcinogen such as urinary nitrate to an active carcinogen such as nitrosamine by the fecal bacteria that have demonstrated the ability to make such a chemical conversion.[26] Some investigators have suggested that the presence of both feces and urine in the colon are necessary for carcinogenesis. But, colonic adenocarcinomas have now been reported in both colon conduits and in ileocecal cystoplasties in humans suggesting that urine without feces may also be carcinogenic.[27] Experiments by Strachan have shown that diversion of urine into the colon leads to an increase in proliferative activity in the epithelium whether or not feces is present.[27]

Discussion and Conclusion

The carcinogenic factors in our patient cannot be clearly determined. Factors relating to her congenital bladder exstrophy as well as her defunctionalized ureterosigmoidostomy may or may not have a role to play in the carcinogenesis. Signet ring adenocarcinomas of the rectosigmoid have been known to occur in the absence of these risk factors. In the past, when the medical community became aware that ingestion of diethylstilbestrol by pregnant women resulted in carcinogenesis in the offspring, a unified effort was made to form a registry with the hope of helping these young victims. Similarly, when it was known that radiation therapy administered to the head and neck region of young people for benign conditions resulted in later years in development of thyroid cancer, a concerted public education campaign was undertaken to screen the patients early. Due to a recent increase in the frequency of case reports, we recommend a concerted effort to form a registry on a state and/or national level, combined with a public education campaign, to trace patients with ureterosigmoidostomy, a procedure suspected or known to be carcinogenic since 1929. Hospital based reviews and registries are probably inadequate to reach patients treated over several decades in a mobile society such as ours.

Acknowledgement

The author wishes to thank Mr. Mark Ingram for the help provided in literature search and translation service and to Mrs. Valerie Cullen for patiently typing the several revisions of this manuscript.

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Childhood Cancer Clinical Trials and Regional Tumor Registries

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Salvatore J. Bertolone, MD, FAAP
Pamela Scott, MSN, BSN

Management of patients with childhood malignancy at multidisciplinary pediatric regional centers has correlated with improved survival and cure. The Kosair Children's tumor registry was reviewed from its inception in 1954 through 1983 to evaluate five-year survival rates. Nine hundred and thirteen patients were entered into the registry during these 30 years. Survival rates were calculated into ten-year periods. Five-year survival rates by decade were as follows: 1954-63 (4%), 1964-73 (22%) and 1974-83 (61%). These data correlate with the national survival rates expected for childhood malignancy. The regional multidisciplinary pediatric oncology teams at Kosair Children's Hospital can achieve cure rates comparable to those of major oncology referral centers. This has been achieved through the use of the multidisciplinary approach, use of national pediatric oncology protocols, and data management.

Childhood cancer will strike over 100 children in Kentucky this year. It is the second leading cause of death in children ages two through 16 years old.[1] Many primary care physicians in communities across the state will have the responsibility for referral of these children to appropriate centers for diagnosis, treatment, and follow-up. Should these children, their families, and family support systems be disrupted by referral to major cancer centers at far distances across the country? Should they be referred to the local community hospital or can they be referred to a regional tertiary care pediatric facility?

Management at a multidisciplinary pediatric institution during the critical phase of diagnosis and therapy has correlated with improved survival for these children. In the past, there have been only a handful of major cancer centers which led the way in pediatric cancer treatment. Most of these centers are far removed from Kentucky. Today, pediatric cancer patients are routinely treated at regional pediatric tertiary centers around the country. The use of cooperative study groups and clinical trials in these regional centers has been credited for the recent successes and cure rates for childhood cancer.[2]

The Division of Pediatric Hematology/Oncology of the University of Louisville at the Kosair Children's Hospital performed a retrospective study to calculate five-year survival rates on the 913 patients followed in the Kosair Children's tumor registry.

Data Collection

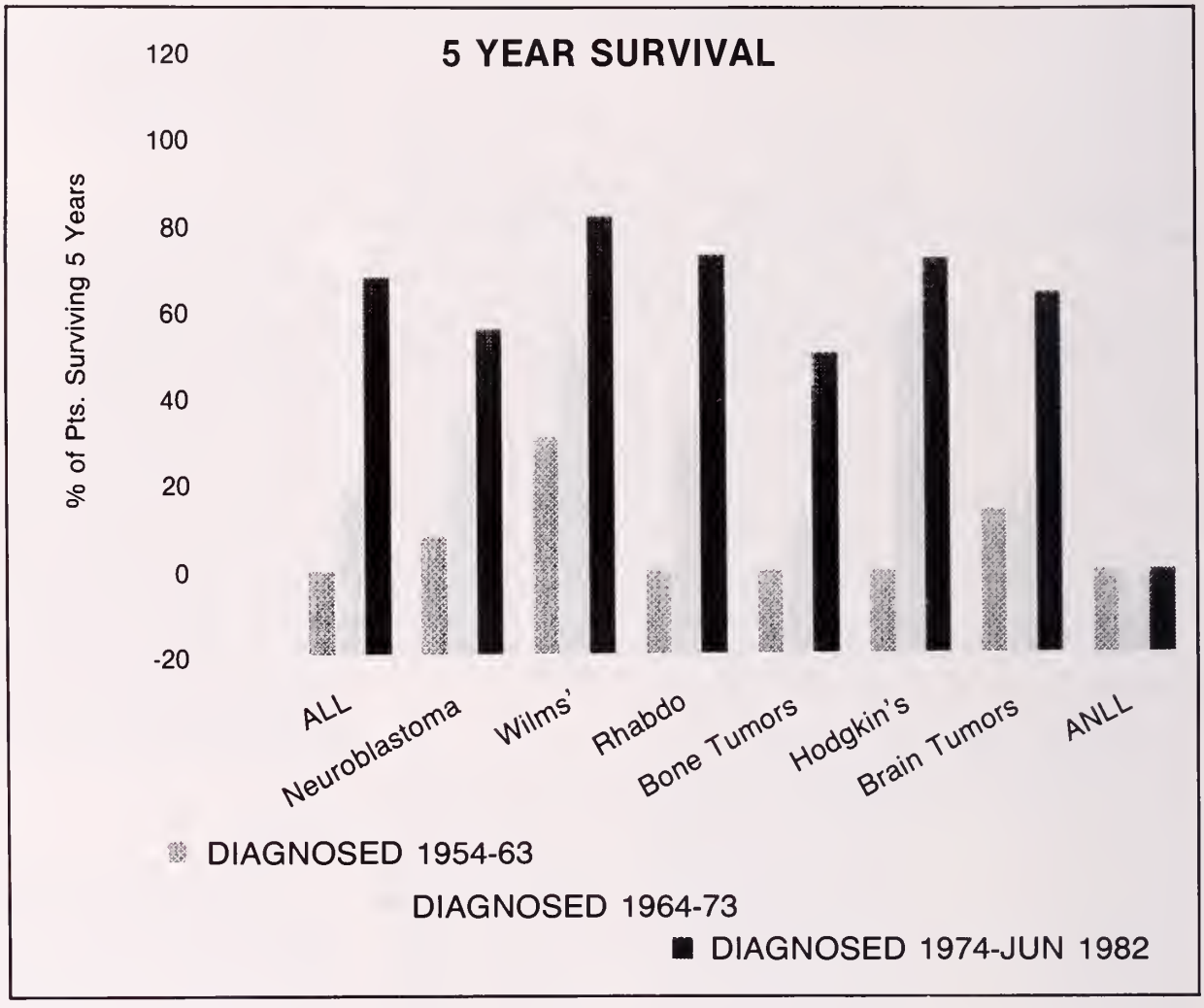
The Kosair Children's Hospital tumor registry was reviewed from its inception in 1954 through December 1983. All patient data were reviewed for diagnosis. Cases were divided into three 10-year periods for evaluation. From 1954-1963, 260 patients were diagnosed with cancer. During the decades 1964-1973 and 1974-1983, 286 and 367 patients respectively were diagnosed with cancer. The children surviving at five years were calculated for each decade and expressed as percentages for the major pediatric disease groups. For the last decade, 1974-1983, only those children diagnosed prior to June 1982 were included for five-year survival data. The major disease groups included acute lymphocytic leukemia (ALL), acute nonlymphocytic leukemia (ANLL), neuroblastoma, Wilms' tumor, rhabdomyosarcoma, brain tumors, bone tumors, and Hodgkin's disease.

Results

During the period 1954-1963, there were no five-year survivors with ALL, ANLL, rhabdomyosarcoma, bone tumors or Hodgkin's disease. Only two of 24 patients with neuroblastoma, four of 13 patients with Wilms', and six of 43 patients with brain tumors survived five years. The group survival during this first decade was ten of 200 patients, or 5%.

During the period 1964-1973, there were no five-year survivors with ANLL. Five-year survival rates by specific disease were as follows: bone — 1 of 8 (12%); rhabdomyosarcoma — 5 of 14 (36%); brain — 10 of 50 (20%); ALL — 15 of 75 (20%); neuroblastoma — 14 of 36 (39%); Wilms' — 17 of 31 (55%); and Hodgkin's — 3 of 5 (60%). The group survival during this second decade was 65 of 286 patients, or 22%.

During the period 1974-1983, there were no five-year survivors with ANLL. Five-year survival rates by specific disease were as follows: bone — 13 of 26 (50%); neuroblastoma — 23 of 41 (56%); brain — 25 of 39 (64%); ALL — 63 of 93 (68%); Hodgkin's — 8 of 11 (72%); rhabdomyosarcoma — 8 of 11 (72%); and Wilms' — 23 of 28 (82%). The group survival during this



third decade was 163 of 261, or 62%. Graph 1 summarizes this thirty-year experience. Data is presented by decade for each major childhood malignancy.

Discussion

During the past thirty years, great progress has been made in the treatment of children with malignancy. One-half of the children diagnosed with ALL thirty years ago died within six months.[2] In pediatric tumors when surgery was the only therapeutic modality, two-year survival ranged from 0% to 20%. With the advent of clinical trials, such as those sponsored by the Children's Cancer Study Group (CCSG), mortality has decreased significantly. These carefully coordinated clinical trials combine the modalities of surgery, radiotherapy and chemotherapy. They are producing a greater than 70% long-term survival of children with ALL and an approximate 70% two-year survival of children with most types of solid tumors.[3]

A major factor in the success in pediatric oncology is the fact that the majority of the children diagnosed with cancer in the United States are entered into clinical trials. Clinical trials are designed to provide the best known therapy and to answer new therapy questions. Meadows et al[4] studied 327 children with ALL. Treatment according to protocol (clinical trials) was associated with improved survival, yielding a four-year survival of 60% vs 19% for non-protocol patients. Children with cancer are usually referred by their primary physicians to major pediatric medical centers. Like Kosair Children's Hospital, many of these institutions participate in national cooperative clinical trials which have

criteria for diagnosis, treatment, and evaluation.

As a member of the CCSG, which involves 36 major pediatric medical centers and over 60 affiliated institutions throughout this country and Canada, Kosair Children's Hospital uses a multiple disciplinary approach to treating pediatric cancer patients. Through participation and affiliation with CCSG, the latest treatment modalities, ie, experimental drugs, treatment protocols, and standard of care that are developed and practiced at major cancer centers, can be transferred to local pediatric tertiary care centers.[5] Local resources that allow for this transfer of patient care include: the team approach in pediatric surgery, radiology, hematology/oncology, immunology, pathology, radiotherapy and a pediatric oncology unit with special nursing care, infectious surveillance, and data and protocol management capabilities.

Currently, approximately 50 new cases of pediatric malignancy are diagnosed annually. Each case identified is followed by Kosair Children's Hospital Cancer Registry which has been functioning since 1954. This registry review supports the conclusion that survival data for children with malignancy treated at Kosair Children's Hospital meets or exceeds comparable national cure rate data for childhood malignancy.

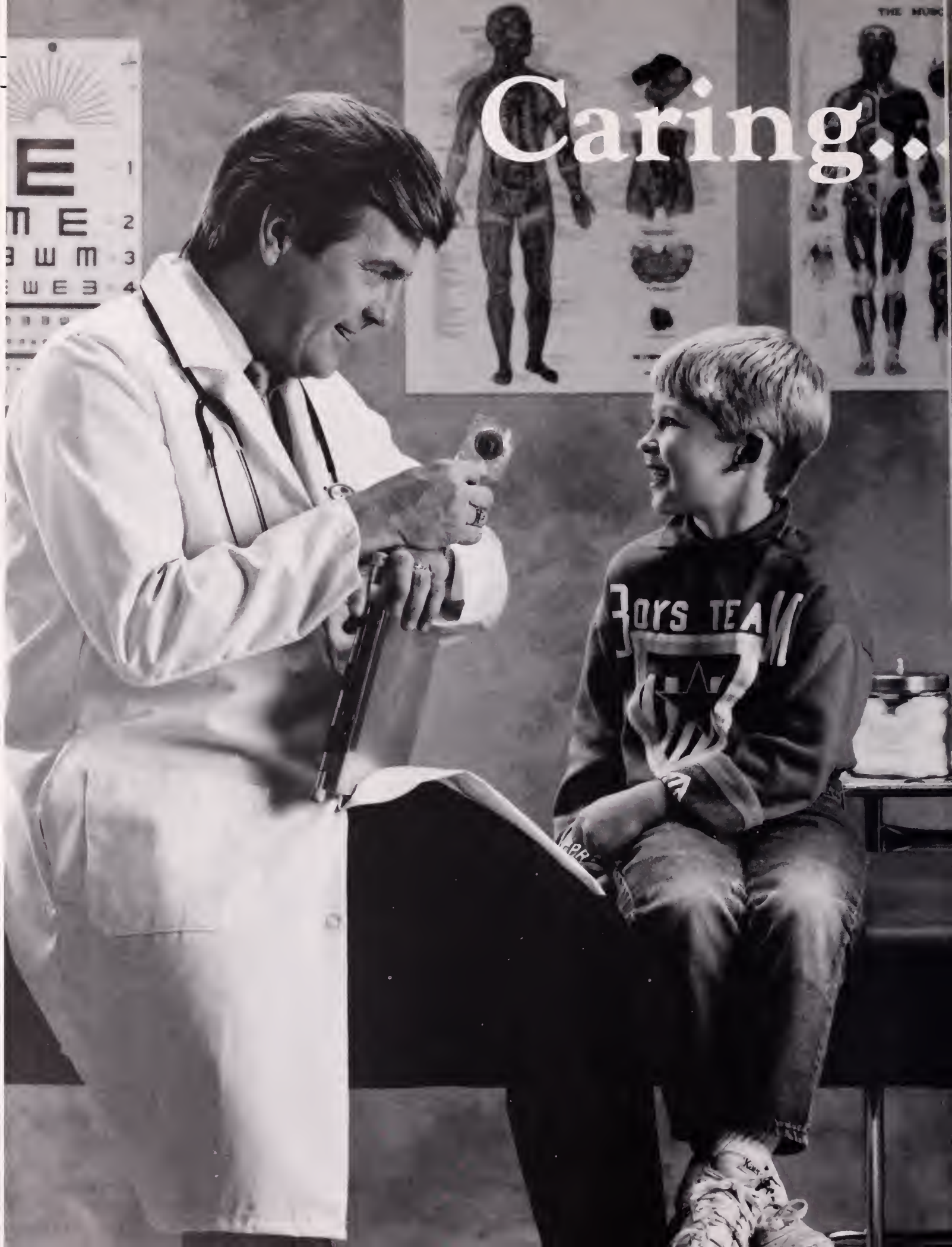
Regional care for children with cancer offers several distinct advantages. The obvious advantage being the most current treatment available for the best chance of cure. Equally important is that regional care causes minimal disturbance to the family structure. Many children can receive phases of therapy at their local physician's office, attend school in their community, and not have to travel long distances to referral cancer centers. Exchange of information between local physicians and those at our medical center is often more consistent and manageable than when the patient is treated in another part of the country. Review of the Cancer Registry has provided detailed studies of the treatment of referred cancer patients. This vital information available on particular cancers diagnosed within the region can also be used as a measure of quality assurance.

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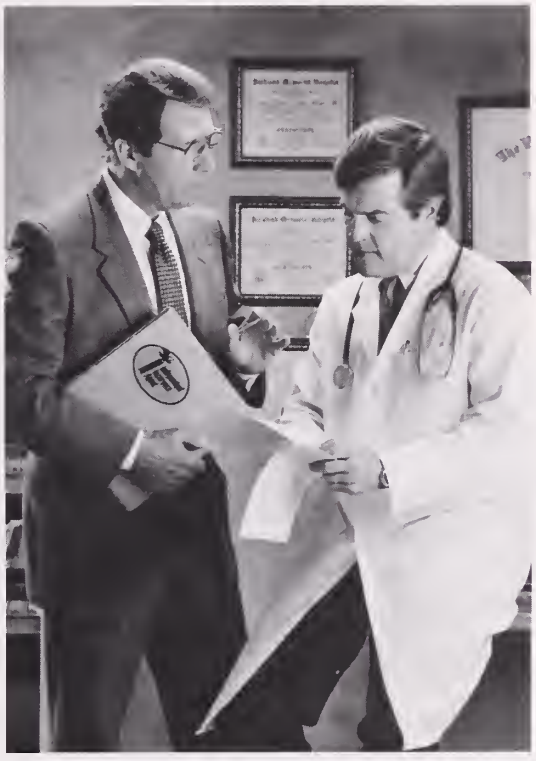

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Remember Jack London's classic novel *The Call of the Wild*? Remember Buck the mixed breed of St. Bernard and Scotch Shepherd dog? Remember John Thornton, the man in the Yukon in search of gold, who eventually is the owner of Buck? Remember their man-dog relationship that grew day by day in mutual trust and faith? Remember all of that . . . and the stage is set.

Thornton is in the Eldorado Saloon one day enjoying the envy of the other men toward him and his dog. In a moment of rash braggadocio, Thornton bets $1,000 that Buck can "break out" and carry a 1,000 pound load for 100 yards on a sled.

Outside Buck is hitched to the sled, its runners frozen to the snow. Before the attempted pull begins, Thornton kneels beside Buck and whispers in his ear, "As you love me Buck, as you love me."

All is ready, and Thornton commands, "Now Buck," and Buck leans and tightens the traces and harness. "Gee!" Thornton's voice rings out, and Buck strains to the right with a sudden jerk and a snap is heard as the runner cracks from the ice. "Haw!" Thornton commands, and Buck lunges to the left to free the other runner from its icy grip. "Mush!" pleads Thornton, and Buck digs in his foot pads for a better purchase on the snow and with a jarring lunge begins to move the heavy sled one-half inch . . . one inch . . . two inches . . . thru the crisp snow. Keeping his head forward and his back low and his powerful hind legs well dug in, Buck maintains the momentum to carry the sled the required 100 yards. The bet is won.

Now that is a nice little vignette, but just where is the analogy to medicine or physicians. Well, I say we doctors are the Bucks, and our patients and medicine are and become our John Thorntons. We love what we do, and we do it rather well. We have a very special relationship with our patients that if not enviable is at least sacrosanct.

And gentlemen, our sled grows heavy and is being made heavier from many sources. Medicare has run the gauntlet from full care for all and hang the expense to less care for most and do it cheaper. As the coffers thin the government offers carrot and stick in attempts to coerce acceptance of Part B assignments. They insist on separate billings for laboratory charges and ICD and CPT numbers of all diagnoses or operations.

Try to get a hospital bed for a sick patient and describe to some clerk the diagnosis and plan of treatment to justify hospitalization and God help you if therapy does not include intravenous fluids, antibiotics and injections of analgesia. Let that patient stay a day too short or a day too long and either the insurance companies or the hospital discharge planners are on you like the mongoose grabs the cobra.

Adding to the load are the malpractice premiums levied by insurance companies as they scurry about to stay solvent or reap obscene profits. The cost of this insurance often drives the best of us from practice or makes us avoid essential procedure needed by the public (obstetrical care) because of the high risk.

Hospital administration ask us to give more and more spare time (and without remuneration) to committee assignments so the hospital can pass the scrutiny of Joint Accreditation and thus still qualify for Medicare Part A. Hospital staff members shift from active to courtesy as the demands for being active staff grow heavy and privileges thin away to non-existence; and the dues are more. Medical Records hound us for timely dictated admission notes and discharge summaries and attestation sheets so they may file for payment.

Growth in medical knowledge and technique explodes like popcorn on a hot skillet, and our ability to absorb, assimilate and retain this information dwindles to almost total eclipse. All this *high tech* state-of-the-art is costly, and the physician dares not to deliver as the sinister spectra of malpractice hovers as an albatross.

The physician strains, gees, haws, and mushes all over these slippery slopes to serve both medicine and patient that he regards equally. We hear the silent refrain of "As you love me, as you love me" while we lean into our traces and harness to pull this load that epitomizes our desire to serve the unfortunate ill.

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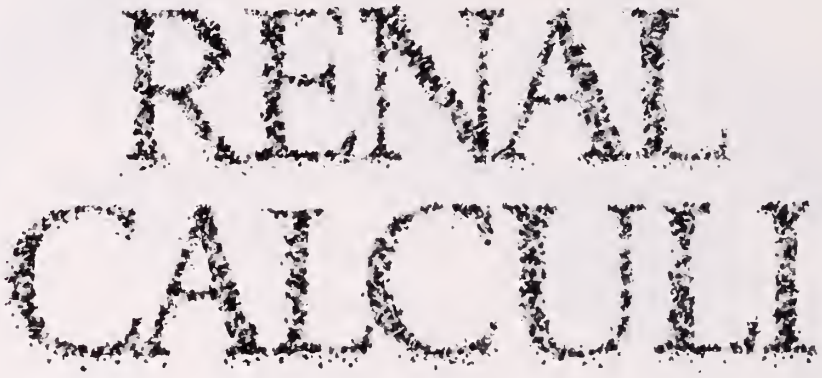
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To the Editor:

This letter is in response to the *President's Page* feature (Vol 86, No. 4, April 1988) written by Nelson B. Rue, Jr, MD, Vice President of the Kentucky Medical Association. Doctor Rue is to be congratulated on the positive yet forthright tenor and substance of his column.

The current shortage of qualified nursing licensees has generated a plethora of *quick fix* opinions from east coast to west coast, from inside and outside the profession, but it is unfortunately true that most of these opinions miss the mark so neatly hit by Doctor Rue. He cited symptom after symptom of the malady which underlies the chief complaint . . . medical staff complaints, the feeling of being unable to meet patient's needs . . . pressure from hospital administrators . . . using RNs on a part-time, PRN basis with no benefits package, shift hours, holiday hours, and a pay scale generally lower than jobs for persons with comparable education . . . treatment of our fellow nursing professionals is too often unprofessional. . . .

Each of these (and unfortunately the list is not complete) taken in isolation appears to be a causative factor which generates an effect — stress, opting out, short staffing, etc. Viewed in context, however, these isolated abstractions become concrete realities, and the underlying problem becomes abundantly clear — simply stated, nursing is a profession not valued. What we are dealing with as a chief complaint — the nursing shortage — is not really the problem, but rather merely a symptom.

Given this premise, the real issue is whether this lack of value can be changed, and I don't just mean on the part of a physician who is momentarily grateful to the nurse who calls at 3:00 AM and provides the succinct information necessary to diagnose a dissecting aortic aneurysm, or an administrator who is similarly momentarily grateful that the quality assurance nurse recognized a resolvable problem that not only reduces risk for patients but also makes the comptroller happy by reducing the length of stay for a given DRG. These too, are isolated occurrences, and the solution is, like the problem, much more complex than that. Organized nursing via such entities as the National League for Nursing, the American Nurses' Association, the American Organization of Nurse Executives, the National Federation of Licensed Practical Nurses, and the National Council of State Boards of Nursing, is working together at both national and statewide levels to develop coherent strategies to address the problem. Because nursing care is not delivered in isolation, much of this work has taken place in multidisciplinary work groups such as the Kentucky Multidisciplinary Task Force on which Doctor Rue serves as the Kentucky Medical Association representative.

Based on recent positive outcomes and the unlimited possibilities of such activities, I would like to be as optimistic about the future of the profession as is Doctor Rue. It becomes more difficult to do so however, when at a time when the profession needs evidence of collegial support and recognition of its worth more than ever, instead we are faced with totally contrary evidence from, of all places, the American Medical Association. The February 1988 AMA proposal for the creation of an entity known as the registered care technologist is being widely perceived as a clear message from medicine to nursing that nurses can easily be replaced by minimally trained technicians. I would submit that if the premise is accepted that the current nursing shortage is an effect of the lack of value placed on the profession, such a proposal is antithetical to the solution and, in fact, is *part of the problem*.

How refreshing that here in the Commonwealth, organized medicine has chosen to participate in efforts to solve rather than exacerbate the problem.

Mary A. Romelfanger, MSN, RN
President, Kentucky League for Nursing, Louisville, KY

To the Editor:

Of the ongoing proliferation of articles, news media coverage, and speeches about the nursing shortage, you are commended for publishing the *President's Page* written by Nelson B. Rue, Jr, MD, KMA Vice President, in the *Journal of the Kentucky Medical Association* (April 1988 issue). Articulately focusing on key issues and calling for solutions by cooperative efforts, Doctor Rue spoke gently but firmly in his description of the situation. Thank you for these words of encouragement — there is hope.

Sharon M. Weisenbeck, MS, RN
Executive Director
Kentucky Board of Nursing
Louisville, KY



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— AKMA Fall Board —
Something for Everyone

The KMA moves to Lexington for its Annual Session, and the Auxiliary is busily planning an agenda that offers "Something for Everyone."



Lexington Home Tour and Luncheon
Legislative Know How Seminar
Leadership Training for County Officers and County Committee Chairmen
Fashion Show and Luncheon
Fall Board Meeting
Hospitality
Medical School Deans Report on AMA-ERF Funds

All KMA spouses are cordially invited to attend the many planned activities. Additional information on scheduled events will be available at the Auxiliary registration desk and in the *Bluegrass News*.

AGENDA

Monday, September 26

12:00 - 2:00 PM	AKMA Hospitality Suite open
10:00 - 2:00 PM	Registration & Information — Hotel Lobby (Luncheon tickets available)
11:00 - 2:00 PM	AKMA Committee meetings — Washington Room
2:00 - 4:00 PM	**"THE TIME TO GET INVOLVED IS NOW" — Susan Bryant, national political consultant** — Chicago/Atlanta Room — *Open to all KMA attendees*
4:00 - 6:00 PM	AKMA Hospitality Suite open
6:00 - PM	KEMPAC Dinner/Seminar — Susan Bryant — speaker

Tuesday, September 27

7:30 - 9:00 AM	AKMA Hospitality Suite open
8:30 - 11:30 AM	Registration & Information — Hotel Lobby
9:00 - 12:00 NOON	AKMA Fall Board Meeting — Regency Ballroom West Open to all AKMA members
12:00 - 1:15 PM	Luncheon & Informal Modeling — Regency Ballroom Center & East — Open to all KMA attendees
1:30 - 4:00 PM	AKMA County Leadership Confluence — For all county officers and committee chairmen — Regency Ballroom West
3:30 - 5:00 PM	AKMA Hospitality Suite open
5:30 - 7:00 PM	Reception honoring KMA & AKMA Presidents

Wednesday, September 28

7:30 - 9:00 AM	AKMA Hospitality Suite open
11:00 - 2:00 PM	"A Day With Fayette County Auxiliary" (tour of FCMA homes)
5:00 PM	AKMA Hospitality Suite open

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AKMA President



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ROSALYN P. STERLING-SCOTT, M.D.

Assistant Professor of Surgery, UCLA School of Medicine and Drew University of Medicine and Science, Los Angeles

Associate Surgeon, Department of Cardiovascular & Thoracic Surgery, Centinela Hospital Medical Center, Los Angeles

Major, U.S. Army Reserve

EDUCATION Rensselaer Polytechnic Institute, Troy, NY, B.S. Chemistry; NYU School of Medicine, New York, M.D.

RESIDENCY Boston University School of Medicine (Cardiovascular); Saint Vincent's and St. Claire's Hospitals, New York City (General Surgery)

FELLOWSHIP First Mary A. Fraley Cardiovascular Surgical Research Fellow at the Texas Heart Institute, Houston

OUTSTANDING ACHIEVEMENTS Author of numerous articles, including "Indications for Early Bypass Grafting Following Intracoronary Streptokinase"; author of "The Female Surgeon—Dawn of a New Era," chapter in *A Century of Black Surgeons—The U.S.A. Experience*; Board of Directors, Association of Black Cardiologists; Secretary, Drew Society

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Indications and Usage: Axid is indicated for up to eight weeks for the treatment of active duodenal ulcer. In most patients, the ulcer will heal within four weeks.

Axid is indicated for maintenance therapy for duodenal ulcer patients, at a reduced dosage of 150 mg h.s. after healing of an active duodenal ulcer. The consequences of continuous therapy with Axid for longer than one year are not known.

Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system, therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—*Pregnancy Category C*—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported; it was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGDT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGDT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalities were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology studies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermatitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LD_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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1988 Annual Meeting Section

KMA Officers for 1987-88	432
District Trustee Map	436
KMA Delegates	439
Reference Committee Activity	442
Nominating Committee	443
Special Features	444
KEMPAC Program	447
Program Summary	448
Scientific Program	449
Summaries of Presentations	461
Technical Exhibits	467

What's new in Cancer Therapy

Official Call KMA Annual Meeting

To the officers and members of the component and county medical societies of the KMA.

Meeting Place
The Annual Meeting of KMA will convene on Tuesday, Wednesday, and Thursday, September 27, 28, 29 at the Hyatt Regency Lexington/Lexington Center. The first General Session will be called to order at 8:30 AM, Tuesday.

The House of Delegates
The first regular meeting of the House of Delegates will convene at 9:00 AM, Monday, September 26, in the Hyatt Regency Ballroom. The second regular business meeting will begin at 6:00 PM, Wednesday, September 28, in the Hyatt Regency Ballroom.

Registration
The registration desk will be open for Delegates in the Hyatt Regency Ballroom Foyer at 7:30 AM, Monday, September 26, and at 5:00 PM, Wednesday, September 28. General registration will be held at the registration desk in the General Registration Area of the Lexington Center from 7:00 AM until 5:00 PM, Tuesday; 7:30 AM to 4:00 PM on Wednesday; and 8:00 AM to 3:30 PM on Thursday.

KMA Officers 1987-88



Donald C. Barton, MD
KMA President



Bob M. DeWeese, MD
President-Elect
Louisville

Bob M. DeWeese, MD, will be installed as President of the Kentucky Medical Association at the President's Luncheon on Wednesday, September 28.

Doctor DeWeese, a native of Ballard County, Kentucky, received his MD degree from the University of Louisville in 1961. He completed a General Surgery residency at the University of Louisville Hospitals in 1966 and has been in the private practice of surgery since that time. Doctor DeWeese is an Assistant Professor of Clinical Surgery at the University of Louisville School of Medicine. He is a Fellow of the American College of Surgeons, a Diplomate of the American Surgery Board, and a member of the Kentucky Surgical Association.

Doctor DeWeese is a past President of the Jefferson County Medical Society and the Louisville Surgical Society. He served KMA as Fifth District Trustee for six years; as Vice Chairman of the Board of Trustees in 1986-87; and on numerous committees.



Vice President
Nelson B. Rue, MD
Bowling Green

Nelson B. Rue, MD, is a surgeon from Bowling Green and a 1956 graduate of the University of Louisville School of Medicine. He is a member of the Warren County Medical Society; AMA; American College of Surgeons; and a Diplomate of the American Board of Surgery. Doctor Rue served KMA as 6th District Trustee from 1981-1987; Chairman of the Board of Trustees 1984-1987; and currently serves as Chairman of the Trends Committee.



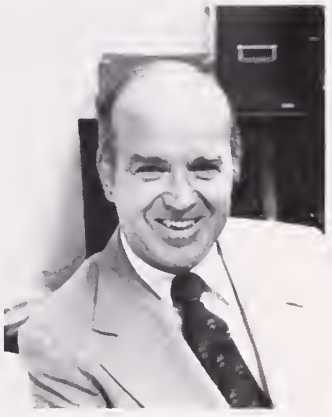
Speaker of the House
Peter C. Campbell, Jr, MD
Louisville

Doctor Campbell, an ophthalmologist, is Clinical Professor of Ophthalmology at the University of Louisville School of Medicine. He is past President of the Jefferson County Medical Society and a member of the American Academy of Ophthalmology and Otolaryngology, the Kentucky Academy of Eye Physicians and Surgeons, and is past President of the medical staff at Methodist Evangelical Hospital.



Vice Speaker of the House
Danny M. Clark, MD
Somerset

Danny M. Clark, MD, is an obstetrician-gynecologist from Somerset and a graduate of the University of Cincinnati College of Medicine. Doctor Clark has served KMA as Delegate from 1974-80; 12th District Alternate Trustee from 1977-80; and 12th District Trustee from 1980-86. He serves as Chairman of the Committee on Maternal and Child Health. Doctor Clark is a Fellow in the American College of Obstetricians and Gynecologists.



Secretary-Treasurer
S. Randolph Scheen, MD
Louisville

Doctor Scheen was KMA Secretary for eight years before his election as Secretary-Treasurer in 1975. A dermatologist, he is a graduate of the University of Louisville and University of Minnesota medical schools. Doctor Scheen serves the Association as a member of the Budget Committee and Judicial Council. He is a member of the American Academy of Dermatology and the Alumni Foundation of the Mayo Clinic, and is a regular participant on local television and radio programs, answering questions from the public on dermatology.

KMA Delegates



Fred C. Rainey, MD
Elizabethtown

Doctor Rainey was elected as AMA Delegate in 1974, having previously served as President of KMA, Alternate AMA Delegate, and Board Chairman of KEMPAC. A 1955 graduate of the University of Tennessee College of Medicine, Doctor Rainey is a family physician. He is a member of the American Medical Political Action Committee, the Kentucky Academy of Family Physicians, and the American Academy of Family Physicians.



Donald C. Barton, MD
Corbin

Donald C. Barton, MD, a family practitioner, was elected AMA Delegate in 1984. A past Chairman of the KMA Board of Trustees, Doctor Barton served as KMA Delegate from 1977-79 and AMA Alternate Delegate in 1983. He is past President of the Whitley County Medical Society; past chairman of the KEMPAC Board; and was 15th District KMA Trustee from 1978-84. Doctor Barton is a 1960 graduate of the University of Louisville School of Medicine.



Kenneth P. Crawford, MD
Louisville

Doctor Crawford was elected an AMA Alternate Delegate in 1977 and served consecutive terms until his election as a Delegate in 1987. He has served KMA on numerous committees and is currently a member of the Rules Committee of the House of Delegates and the Committee on Constitution and Bylaws. Doctor Crawford, a pediatrician, earned his medical degree in 1946 from the University of Louisville School of Medicine and is Medical Director of the Commission for Handicapped Children. He is a member of AMA, a Fellow in the American Academy of Pediatrics, and a Diplomate of the American Board of Pediatrics.



Russell L. Travis, MD
Lexington

Doctor Travis is Associate Clinical Professor of Neurosurgery at the University of Kentucky School of Medicine and attending neurosurgeon at Central Baptist Hospital, Good Samaritan Hospital and Humana Hospital of Lexington. He is past President of the Kentucky Neurosurgical Society and is currently Chairman of the KMA Hotline Operating Committee. Doctor Travis has served as a member of the KMA Board of Trustees, KMA Membership Committee, and is Treasurer of the Kentucky Health Care Access Foundation. He is a 1962 graduate of the University of Louisville School of Medicine.

Journal Editors

A. Evan Overstreet, MD, Editor
Louisville
Doctor Overstreet had served on the Editorial Board for more than six years before becoming Editor of *The Journal* in September 1977. An internist, Doctor Overstreet is a 1955 graduate of the University of Louisville School of Medicine. He is a member of the American Society of Internal Medicine, the American College of Physicians, the Transylvania Medical Society, and former President of the Louisville Society of Internists.

Paul C. Grider, Jr, MD
Louisville
Doctor Grider has served as Scientific Editor of *The Journal* since 1975. An internist, Doctor Grider was President of the Louisville Society of Internists from 1976 to 1977 and former President of the medical staff at Methodist Evangelical Hospital. Doctor Grider is a 1958 graduate of the University of Louisville School of Medicine.

Milton F. Miller, MD
Louisville
Doctor Miller is Associate Clinical Professor of Medicine at the University of Louisville School of Medicine. An internist, Doctor Miller has served as Assistant Editor of *The Journal* since 1976, has been on the Membership Committee of the Jefferson County Medical Society, and former President of the medical staff at Methodist Evangelical Hospital. He is a 1954 graduate of the University of Louisville.

Stephen Z. Smith, MD
Louisville
Doctor Smith has served as Assistant Scientific Editor for *The Journal* since 1977. A dermatologist, Doctor Smith is a 1971 graduate of Johns Hopkins University School of Medicine. He is a member of the KMA Claims and Utilization Review Committee, the American Academy of Dermatology, and the American Medical Association.

David L. Stewart, MD
Louisville
Doctor Stewart, a former Editor of the Jefferson County Medical Society Bulletin, is in his tenth year as Assistant Editor of *The Journal*. A psychiatrist, Doctor Stewart graduated from the University of Louisville in 1946, is a member of the American Psychiatric Association, and is Chairman of the KMA Committee on Impaired Physicians.

McHenry S. Brewer, MD
Louisville
Doctor Brewer is serving his fifth year as Assistant Editor of the *Journal of the Kentucky Medical Association*. A surgeon, Doctor Brewer attended the University of Louisville School of Medicine and was President of the Jefferson County Medical Society in 1972-73. He is a fellow of the American College of Surgeons and a member of the Southern Surgical Association.

Martha Keeney Heyburn, MD
Louisville
Doctor Heyburn joined *The Journal* in 1986 as an Assistant Editor. An ophthalmologist, Doctor Heyburn is a 1980 graduate of the University of Louisville School of Medicine. She has served the Jefferson County Medical Society as an Alternate Delegate to KMA, is a member of the American Academy of Ophthalmology, the American Medical Association, and has been a member of KMA since 1981.

KMA District Trustees



John D. Noonan, MD
First District





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Fifth District





Albert H. Joslin, MD
Second District





Jerry W. Martin, MD
Sixth District





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Fifteenth District





David C. Liebschutz, MD
Twelfth District



New Trustees

Larry P. Griffin, MD
Louisville
Larry Paul Griffin, MD, is serving as Trustee from the 5th District. An OB/GYN, Doctor Griffin is a Fellow of the American College of Obstetricians and Gynecologists and a member of the American Fertility Society and the National Perinatal Association. He is an Assistant Clinical Professor in the Departments of Family Practice and OB/GYN at the University of Louisville School of Medicine and Chairman of the OB/GYN Department of Methodist Evangelical Hospital. Doctor Griffin received his medical degree in 1973 from the University of Louisville School of Medicine.

Jerry W. Martin, MD
Bowling Green
Jerry Wayne Martin, MD, is serving as Trustee from the 6th District. A family practitioner, Doctor Martin is a Diplomate of the American Board of Family Practice and a Fellow of the American Academy of Family Physicians. He is a past President of the Warren County Medical Society and a member of the Board of Directors of KEMPAC. Doctor Martin received his medical degree in 1963 from the University of Louisville School of Medicine.

William H. Mitchell, MD
Richmond
William Harrison Mitchell, MD, is serving as Trustee from the 11th District. A surgeon, Doctor Mitchell received his medical degree in 1970 from the University of Kentucky Medical School. He is a member of The American Society of Gastrointestinal Endoscopy, American College of Surgeons, and a past President of the Madison County Medical Society. Doctor Mitchell also serves on the KMA Physician Manpower and Membership Committees.

KMA Delegates

Adair
Oris Aaron, MD, Columbia

Allen
Earl P. Oliver, MD, Scottsville

Anderson

Ballard

Barren
Daryl P. Harvey, MD, Glasgow
William Marrs, MD, Glasgow

Bath
Robin A. Byron, MD, Owingsville

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Meredith J. Evans, MD, Middlesboro

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Breckinridge

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James R. Cundiff, Jr, MD, Shepherdsville

Butler
Richard T. Wan, MD, Morgantown

Calloway
Robert G. Marquardt, MD, Murray
Dan Miller, MD, Murray

Campbell-Kenton
Charles F. Allnutt, MD, Covington
Thomas E. Bunnell, MD, Erlanger
Luis E. Davila, MD, Ft. Thomas
Joel G. Kreilein, MD, Erlanger
Carol S. Milburn, MD, Crestview Hills
Mary Redden-Borowski, MD, Erlanger
Jeffrey W. Russell, MD, Ft. Thomas
Donald A. Saelinger, MD, Ft. Thomas
Frederick A. Stine, MD, Highland Heights
Steven M. Woodruff, MD, Ft. Thomas

Carlisle

Carroll
Jeffrey S. Bisker, MD, Carrollton

Carter

Casey
Lewis E. Wesley, MD, Liberty

Clark

Clay
William E. Becknell, Sr, MD, Manchester

Clinton

Crittenden

Cumberland

Daviess
John D. Jefferies, MD, Owensboro
Christopher R. McCoy, MD, Owensboro
R. Wathen Medley, MD, Owensboro
Wayne C. Myers, MD, Owensboro
W. Neil Padgett, MD, Owensboro

Edmondson
Omkar N. Bhatt, MD, Brownsville

Elliott

Estill

Fayette
John R. Allen, MD, Lexington
Peter P. Bosomworth, MD, Lexington
John W. Collins, MD, Lexington
John D. Cronin, MD, Lexington
Michael E. Daugherty, MD, Lexington
Harold T. Faulconer, MD, Lexington
John M. Fox, MD, Lexington
William F. Gee, MD, Lexington
Bill H. Harris, MD, Lexington
Ardis D. Hoven, MD, Lexington
Thomas M. Jarboe, MD, Lexington
Dennis B. Kelly, MD, Lexington
William D. Medina, MD, Lexington
William R. Meeker, Jr, MD, Lexington
Andrew M. Moore, II, MD, Lexington
Franklin B. Moosnick, MD, Lexington
Andrew R. Pulito, MD, Lexington
Barry N. Purdom, MD, Lexington
Charles R. Sachatello, MD, Lexington
David B. Stevens, MD, Lexington
John E. Trevey, MD, Lexington
Gary R. Wallace, MD, Lexington

Fleming
Glenn R. Womack, MD, Flemingsburg

Floyd
Peeter Jakobson, MD, Prestonsburg
Nicholas R. Jurich, MD, Prestonsburg

Franklin
Joseph J. Dobner, MD, Frankfort
Willis P. McKee, Jr, MD, Frankfort
Walter S. Wilson, Frankfort

Fulton

Gallatin

Garrard

Grant

Graves
Robert D. Fields, MD, Mayfield

Grayson
Ray A. Cave, MD, Leitchfield

Green
Robert L. Shuffett, MD, Greensburg

Greenup
Manuel S. Garcia, MD, Ashland

Hancock

Hardin-Larue
William M. Carney, MD, Elizabethtown
Marion A. Douglass, Jr, MD, Magnolia
Terrell Mays, MD, Elizabethtown
William C. Nash, MD, Elizabethtown

Harlan
Rachel R. Eubank, MD, Harlan
James K. Hurlocker, MD, Harlan

Harrison
Donald R. Stephens, MD, Cynthiana

Hart
George B. Boeckmann, MD, Horse Cave

Henderson
Frank K. Sewell, Jr, MD, Henderson
Rogelio A. Silva, MD, Henderson

Hickman
Bruce C. Smith, MD, Clinton

Hopkins
Wallace R. Alexander, MD, Madisonville
James M. Bowles, MD, Madisonville
Charles R. Dodds, MD, Madisonville
William H. Klompus, MD, Madisonville

Jackson

Jefferson
William S. Aaron, MD, Louisville
James G. Baker, MD, Louisville
Alan M. Bornstein, MD, Louisville
McHenry S. Brewer, MD, Louisville
Jerry B. Buchanan, MD, Louisville
William C. Buschemeyer, Jr, MD, Louisville
Edward L. Callahan, MD, Louisville
E. Dean Canan, MD, Louisville
Stuart P. Cohen, MD, Louisville
Eugene H. Conner, MD, Louisville
J. William Comer, MD, Louisville
Samuel L. Cooper, MD, Louisville
John H. Doyle, MD, Louisville
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Henry D. Garretson, MD, Louisville
Darius Ghazi, MD, Louisville
Norman Glazer, MD, Louisville
S. Philip Greiver, MD, Louisville
John G. Hubbard, MD, Louisville
Walter I. Hume, Jr, MD, Louisville
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Hobert L. Pence, MD, Louisville
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Thomas P. Rankin, MD, Louisville
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Will W. Ward, MD, Louisville
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Barbara Weakley-Jones, MD, Louisville
A. Franklin White, MD, Louisville
Larry J. Wilson, MD, Louisville
David H. Winslow, Jr, MD, Louisville
C. Milton Young, III, MD, Louisville

Jessamine

Johnson

Knott

Knox
Raju N. Vora, MD, Barbourville

Laurel
Paul R. Smith, MD, London

Lawrence
George P. Carter, MD, Louisa

Lee
Arnold L. Taulbee, MD, Beattyville

Leslie
Jean E. Sullivan, MD, Hyden

Letcher
Arba L. Kenner, MD, Whitesburg

Lewis
Karl H. Smith, DO, Vanceburg

Lincoln
Charles E. Crase, MD, Stanford

Livingston
Stephen Burkhart, MD, Salem

Logan

Madison
John M. Johnstone, MD, Richmond
Charles H. Veurink, MD, Richmond

Magoffin

Marion
Brian F. Scott, MD, Lebanon

Marshall
H. W. Ford, MD, Benton

Martin

Mason
Audrey Spencer, MD, Maysville

McCracken

McCreary

McLean

Meade
Raymond L. Mathis, DO, Brandenburg

Menifee

Mercer
George W. Noe, MD, Harrodsburg

Metcalfe
Lawrence P. Emberton, MD, Edmonton

Monroe
James E. Carter, MD, Tompkinsville

Montgomery

Morgan
James D. Frederick, MD, West Liberty

Muhlenberg
William L. Miller, MD, Greenville

Nelson

Nicholas
Timothy R. Scott, MD, Carlisle

Ohio
Eric A. Norsworthy, MD, Hartford

Owen
David F. Smith, MD, Owenton

Owsley

Pendleton
Robert L. McKenney, MD, Falmouth

Pennyrile
Emmanuel J. Battah, MD, Hopkinsville
Henry R. Bell, Jr, MD, Elkton
Ralph L. Cash, Jr, MD, Princeton
Delmas M. Clardy, MD, Hopkinsville
James A. Parrott, MD, Hopkinsville
Francis Van Meter, Jr, MD, Hopkinsville

Perry

Pike
Russell H. Davis, Sr, MD, Pikeville
John H. Scott, III, MD, Pikeville
Mary L. Wiss, MD, Pikeville

Powell
Charles G. Noss, MD, Stanton

Pulaski
Donald E. Brown, MD, Somerset
Gregory J. Sherry, MD, Somerset
Joseph G. Weigel, MD, Somerset

Robertson
R. Lamont Wood, MD, Mt. Olivet

Rockcastle

Rowan

Russell
James E. Monin, MD, Jamestown

Scott
L. Frank McBrayer, MD, Georgetown

Shelby-Henry-Oldham
Sidney R. Steinberg, MD, Shelbyville
Ronald E. Waldridge, MD, Shelbyville
David W. Wallace, MD, Shelbyville

Simpson

Spencer

Taylor
Henry F. Chambers, MD, Campbellsville

Trimble
Roderick H. MacGregor, MD, Bedford

Union
Wallas N. Bell, MD, Morganfield

Warren
Jerry W. Martin, MD, Bowling Green

Washington

Wayne
John W. Simmons, MD, Monticello

Webster

Whitley
Terri Lynn Daniel, MD, Corbin
Carmel Wallace, Jr, MD, Corbin

Wolfe
Paul F. Maddox, MD, Campton

Woodford

KMA Hospital Medical Staff Section
David R. Watkins, MD, Louisville

KMA Resident Physicians Section
Elizabeth M. Tully, MD, Louisville

KMA Student Section
Todd E. Pesavento, Louisville

Reference Committee Activity

Speaker Peter C. Campbell, Jr, MD, Louisville, will assign all officers' and committees' reports and Resolutions to one of six Reference Committees at the first meeting of the KMA House of Delegates at 9 AM, Monday, September 26. A brief session for Reference Committee Chairmen will be held at 12:30 PM, Monday, in the Atlanta Room, located in the Hyatt Suite of the hotel. Any KMA member wishing to testify on any Resolution or report is urged to be present for the Reference Committee meetings which will be held at 2 PM, Monday, September 26, in the meeting rooms in the Hyatt Conference Center of the hotel. These open sessions will last at least one hour in order for all who wish to speak to be heard. Following the open hearings, the Committees will go into executive sessions to study the reports, review the testimony, and write their reports to the House.

The Committees' recommendations will be presented at the final meeting of the House, Wednesday evening, September 28, in the Hyatt Regency Ballroom.

As Speaker of the House of Delegates, Doctor Campbell is in the process of finalizing appointments to the six Reference Committees, Credentials Committee, and Tellers Committee.

If your society has not yet submitted the name of your Delegate(s) to the Headquarters Office, you should do so immediately, as only those names recorded in the office can be considered for appointment to one of these important committees.

A complete listing of members who will be serving on the six Reference Committees and the location of the Reference Committee meetings will be published in the September issue of the KMA *Journal.*

Anyone desiring names of Reference Committee members before the September issue is published should contact the Headquarters Office.

Elections

Nominating Committee to Meet Monday, September 26

The KMA Nominating Committee will hold an open meeting at the close of the first meeting of the House of Delegates, Monday, September 26, in the Regency Ballroom of the Hyatt Regency Hotel in Lexington. Any KMA member may confer with the Committee during this meeting.

The report of the Nominating Committee will be posted in the general assembly hall at the conclusion of the first general session, Tuesday morning, September 27.

Nominations may be made from the floor during the second meeting of the House of Delegates, Wednesday evening, September 28, in the Regency Ballroom. The House will vote on the nominees at this meeting.

Members of the Committee are: Scott B. Scutchfield, MD, Danville, Chairman; R. Gary Marquardt, MD, Murray; Terrell D. Mays, MD, Elizabethtown; William H. Mitchell, MD, Richmond; and Susan H. Prasher, MD, Ashland.

Nominations should be sent before the Annual Meeting to the KMA Headquarters Office, Attention, Nominating Committee.

House to Elect New Officers During Annual Meeting

KMA officers for the 1988-89 Association year will be elected by the House of Delegates at the close of its final meeting, Wednesday evening, September 28. Officers to be elected from the state-at-large are:

Office	Term
President-Elect	One Year
Vice President	One Year
Delegates to the AMA	Two Years
*Kenneth P. Crawford, MD Louisville	
*Russell L. Travis, MD Lexington	
Alternate Delegates to the AMA	Two Years
*Robert R. Goodin, MD Louisville	
*Carl Cooper, Jr, MD Bedford	

*Incumbent

Election of Trustees and Alternate Trustees

The House of Delegates will elect five District Trustees and five Alternate Trustees at its second regular meeting, Wednesday, September 28. Nominations will be made by the Delegates from the electing Districts at a meeting following the first meeting of the House on Monday, September 26.

The Nominating Committee will report at the close of the first scientific session on Tuesday, September 27. Further nominations may be made from the floor at the final meeting of the House on Wednesday evening, September 28. All nominations are considered and acted upon by the Delegates at this final meeting.

Districts electing Trustees for three-year terms are: **Second District** (incumbent, Albert H. Joslin, MD, Owensboro); **Seventh District** (incumbent, Cecil D. Martin, MD, Carrollton); **Ninth District** (incumbent, Kelly G. Moss, MD, Maysville); **Tenth District** (incumbent, Preston P. Nunnelley, MD, Lexington); and **Thirteenth District** (incumbent, Jerald M. Ford, MD, Ashland.)

Districts electing Alternate Trustees are the same as those electing Trustees. Incumbents are: John W. McClellan, MD, Henderson, 2nd District; O. M. Patrick, MD, Frankfort, 7th District; Robert L. McKenney, MD, Falmouth, 9th District; Thomas K. Slabaugh, MD, Lexington, 10th District; and Charles T. Watson, MD, Ashland, 13th District.

Trustees in the 7th, 9th, 10th, and 13th Districts are eligible for reelection, while the Trustee in the 2nd District has served two full, consecutive terms and is not eligible for reelection.

Alternate Trustees in the 7th, 10th, and 13th Districts are eligible for reelection, while the Alternate Trustees in the 2nd and 9th Districts are not eligible for reelection.

Annual Meeting Special Features



1988 Annual Meeting Honors Past President John G. Cecil, MD
The 1988 Annual Meeting of the Kentucky Medical Association will be officially titled, "The John G. Cecil Meeting" in remembrance of the 1908-09 President of the Association. The tradition of honoring a past President of KMA and other distinguished physicians originated at the 1935 Annual Meeting. Eugene H. Conner, MD, Louisville, KMA Historian, has written a biography on Doctor Cecil that begins on page 445.

Scientific Sessions are scheduled for September 27, 28 and 29 at the Lexington Center in Lexington. The theme for the 1988 scientific session is "What's New in Cancer Therapy." Both the presentations and discussion periods will contribute to the continuing medical education of Kentucky's physicians.

Twenty-one Specialty Groups will hold meetings on the afternoons of September 27, 28, and 29. Beginning at 1:30 PM on Tuesday and Thursday and 2:15 PM on Wednesday, they will be held in the meeting rooms of the Hyatt Regency Lexington and Lexington Center. Individual programs of specialty societies are listed in this issue. All general sessions will be held in the mornings. Specialty groups will meet all three afternoons with no general sessions scheduled during these specialty group meetings. All KMA members are invited to attend any specialty meetings.

Scientific and Technical Exhibits will display new medical products, services and techniques in the General Sessions area of the Lexington Center during the 1988 Annual Meeting. Members and guests are urged to take the opportunity to view products of interest at the 30-minute intermissions scheduled during each general and specialty session.

The KMA House of Delegates will meet twice during the Annual Meeting. The first meeting of the House will be held at 9 AM, Monday, September 26, in the Hyatt Regency Ballroom in the hotel. The final meeting will be held Wednesday, September 28, at 6 PM, also in the Hyatt Regency Ballroom. Officers for the 1988-89 Associational year will be elected at the second meeting.

The President's Installation & Awards Luncheon will be held on Wednesday, September 28, in Patterson Ballrooms, located in the hotel. This year's guest speaker during the President's Installation & Awards Luncheon will be the Honorable Brereton C. Jones, Lieutenant Governor of Kentucky, whose topic will be "Indigent Care — The Realistic View from Frankfort." The luncheon will include the presentation of KMA awards and the installation of the 1988-89 President, Bob M. DeWeese, MD, Louisville.

John Giles Cecil, MD 1855-1913

It is a source of pride, as well as pleasure, to discover facts concerning our profession. Most practitioners contribute in some manner to the progress that has characterized the slow, sometimes halting steps toward improvement in diagnosis and therapy. It is a special pleasure to examine the life and work of John Giles Cecil, MD, whom we honor this year at our Annual Meeting.

When Doctor Cecil was installed as President of the KMA (at the Annual Meeting in Winchester, KY) in October 1908, he was probably at the zenith of his career as a practitioner, teacher and leader.[1]

Doctor Cecil was born 20 November 1855 at or near Monticello, Wayne County, Kentucky, the son of Russell Howe Cecil (b. Oct 1815), a banker, and Lucy Ann Phillips Cecil (b. Jan 1828). When he was four years old (1859), his parents and their three sons and two daughters moved to a farm in Mercer County, Kentucky, near Harrodsburg.[2,3]

Our honored president received his preliminary education at McAfee Academy in Mercer County, and in 1873 enrolled in Princeton University, Princeton, New Jersey. Following graduation from Princeton in 1876, he entered the Hospital College of Medicine, Louisville, from which he received his MD with honors in 1878. He then served an internship at the Louisville City Hospital, marking the beginning of a professional relationship which would continue throughout his lifetime.

Following his internship he began to practice general medicine in Louisville. Having thus established himself as a physician with a growing practice, he turned his attention to Miss Elizabeth ("Lizzie") Robinson, daughter of the Rev. Dr. Stuart Robinson of Louisville. They married in 1882 and to them were born six children (three girls and three boys).

In 1884, he began his formal relationship with medical education by accepting an appointment as Assistant to the Professor of Obstetrics, University of Louisville Medical Department. He soon was appointed Obstetrician to the City Hospital (1886), and several years later Gynecologist there.

With his professional focus on obstetrics, gynecology and surgery, he embarked in late September 1893 for a tour of hospitals in London, Oxford, Edinburgh, Dublin, Leipzig, Berlin and Paris. This "tour" he carefully planned for himself with Mr. Thomas Cook's Agency arranging for his transportation and lodging. He observed surgeons operating primarily, but not exclusively, for gynecological disorders. He returned home in January 1894. His letters to his beloved wife, "Lizzie," and their children have just recently been rediscovered and are shared with subsequent generations through the generosity of his grandson, the late Jonathan Van Dyke Norman.[4]



Upon his return to Louisville, Doctor Cecil accepted the appointment of Professor of Obstetrics at the Kentucky School of Medicine. He served as Professor of the Principles and Practice of Medicine and Clinical Medicine at Louisville Medical College, 1894, and when the medical schools of Louisville were consolidated he carried his chair with him to the University of Louisville Medical Department (1905-1913). Although he held the Chair of Principles and Practice of Medicine and Clinical Medicine, he did not relinquish his interest in obstetrics, especially what today would be called "high risk obstetrics."

Devoted to teaching as well as the practice and the care of patients, he was an active member of several local medical socie-

ties, The Louisville Clinical Society, The Medico-Chirurgical Society (President), and The Jefferson County Medical Society (President). With his colleagues in these societies and the KMA, The Southern Surgical and Gynecological Association and the AMA, he shared his experience and knowledge by presenting papers and participating in discussions. His publications number 58, as extracted from the *Surgeon General's Index Catalogue, Index Medicus*, and individual journal indices.[5] Many are on obstetrics and gynecology but nearly half are on general medical topics. Doctor Cecil later seems to have become much interested in rheumatic fever, valvular heart disease and ulcerative endocarditis (sub-acute bacterial endocarditis) which may reflect his position as a medical examiner for Inter-southern Life Insurance Company.[6]

Doctor Cecil was a devoted member of the Second Presbyterian Church, Louisville, and served as an elder for many years. His Presbyterian heritage was quite strong: his brother the Rev. Dr. Russell Cecil was Pastor of the First Presbyterian Church, Richmond, Virginia, and one of his daughters, Mrs. J. M. (Martha) Wilson, became a missionary in Hangchow, China. He served several terms as President of the YMCA.

Doctor Cecil was generous with his professional time and skills, and he served a number of years as physician to the Masonic Home in Louisville where he was known for "his unfailing solicitude and warm sympathy."[7]

He served the KMA as Councilor and as chairman or member of numerous committees. He was a member of the Executive Committee of the Faculty of the UL Medical Department after the merger of all of the schools in Louisville was completed in 1908.

Doctor Cecil succumbed to heart disease at his home, 1401 St. James Court, Louisville, on 12 December 1913. He was survived by his wife and four children. His professional, public and private life had been spent in large measure for the benefit of others. He was a valuable member of our profession and the KMA.

Eugene H. Conner, MD
KMA Historian

References

1. Cecil JG: President's Address. *JKMA* 1908, 6, 535-540.
2. *Louisville Evening Post*, 13 December 1913.
3. Johnston's *Memorial History of Louisville*, Am Biogr Pub Co 2, 469.
4. Collection of Letters from John G. Cecil, MD, to his wife "Lizzie" and their children from September 1893-January 1894. Transcribed by McHenry S. Brewer, MD, whose wife Elizabeth Cecil Norman "Cecy" Brewer is the great granddaughter of Doctor Cecil. These letters were recently rediscovered by the late Jonathan Van Dyke Norman, former Chairman of First National Bank of Louisville. Xerox copies of this collection have been deposited in the Historical Collections, Kornhauser Health Sciences Library, UL, Louisville.
5. Bibliography of published papers of John G. Cecil, MD, prepared by the author is in the Historical Collections, Kornhauser Health Sciences Library, UL, Louisville.
6. Cecil JG: Stale Points for the Life Insurance Examiners. *JKMA* 1907, 5, (November) 16-18.
7. *The Masonic Home Journal* (January 1914?), clipping without date in John G. Cecil, MD, Collection, Historical Collections, Kornhauser Health Sciences Library, UL.

KEMPAC



You Are Invited
to attend

The 26th Annual KEMPAC Political Seminar

Monday Evening, September 26, 1988
Patterson Ballroom — Hyatt Regency
Lexington, Kentucky

Reception — 6:00 PM EDT
Banquet and Program — 7:00 PM EDT

Featuring

SUSAN B. BRYANT

She has served as a political consultant in US Senate, House, Governor, statewide and local election campaigns, and as a campaign manager in two winning congressional races.

Bryant is the author of the manual on scheduling for political candidates and serves on the editorial board of the magazine *Campaigns* and the professional journal *Elections*. She is a member of the advisory council of the Responsible Government for American Foundation.

She has made many television and radio appearances as an expert on voting patterns and campaign strategy. She is the president of Research/Strategy/Management, Inc., a Washington-based political consulting firm.

LEARN HOW TO HAVE AN IMPACT ON THE POLITICAL PROCESS. Make plans to attend now!

Reservations can be made through your KEMPAC director or by contacting the KEMPAC Office at 3532 Ephraim McDowell Drive, Louisville, Kentucky, 40205 — or telephone (502) 454-3505.

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Larry Franks, MD — 216 Berger Road, Paducah, KY 42001

Second Congressional District
Salem George, MD — 1129 W Chandler, Lebanon, KY 40033
Jerry Martin, MD — 1167 31 W By-pass, Bowling Green, KY 42101

Third Congressional District
K. Thomas Reichard, MD — 100 Baptist East Office Park Bldg, Louisville, KY 40207
Sam D. Weakley, MD — 220 Baptist East Office Park Bldg, Louisville, KY 40207

Fourth Congressional District
Charles F. Allnutt, MD — 2660 Shaker Road, Lakeside Park, KY 41017
John S. Spratt, MD — 529 S Jackson, Louisville, KY 40202

Fifth Congressional District
Harold L. Bushey, MD — 406 Knox Street, Barbourville, KY 40906
Charles C. Moore, Jr, MD — 3603 W Cumberland Avenue, Middlesboro, KY 40965

Sixth Congressional District
John R. Allen, MD — 135 E Maxwell, #104, Lexington, KY 40508
David B. Stevens, MD — 1900 Richmond Road, Lexington, KY 40502

Seventh Congressional District
Samuel J. King, MD — PO Box 3207, Pikeville, KY 41501

Represent Auxiliary to KMA
Mrs. Allen Gregory (Joyce), PO Box 848 — Burnside, KY 42519
Mrs. Wally O. Montgomery (Gerry) — 3690 Marlborough Way, Paducah, KY 42001
Mrs. George Schafer (Pat) — 732 Greenridge Lane, Louisville, KY 40207
Mrs. Russell Lee Travis (Sara Gail) — 744 Cottage Grove Lane, Lexington, KY 40502

1988 Annual Meeting (Program Summary)

Kentucky Medical Association
September 25-29
Hyatt Regency Lexington/Lexington Center

Sunday, September 25

9:00 AM	KMA Executive Committee Meeting	Regency Ballroom ½ Center
12:30 PM	KMA Board of Trustees Meeting & Lunch	Regency Ballroom West

Monday, September 26

7:30 AM	Registration	Hyatt Regency Ballroom Foyer
8:00 AM	Continental Breakfast for House of Delegates, hosted by FCMS	Hyatt Regency Ballroom
9:00 AM	First Meeting, KMA House of Delegates	Hyatt Regency Ballroom
10:00 AM	Auxiliary Committee Meetings	Washington Room/Hyatt
12:30 PM	Luncheon, Reference Committee Chairmen	Atlanta Room/Hyatt
2:00 PM	Reference Committee Meetings	Various Meeting Rooms/Hyatt Conf. Center
2:00 PM	Auxiliary Legislative Seminar	San Francisco/Chicago Rooms/Hyatt
6:00 PM	KEMPAC Reception & Dinner	Patterson Ballrooms/Hyatt

Tuesday, September 27

7:00 AM	KEMPAC Board Breakfast Meeting	Washington Room/Hyatt
7:00 AM	KMIC-sponsored Breakfast	Patterson A/Hyatt
7:00 AM	Maternal Mortality Committee Breakfast	Atlanta Room/Hyatt
7:00 AM	Registration	Registration Area-LC
8:00-9:00 AM	Reference Committee Report Signing	Mary Todd Lincoln/Hyatt
8:30 AM	Opening Ceremonies	General Sessions Area-LC
8:40 AM	First Scientific Session	General Sessions Area-LC
9:00 AM	Auxiliary Fall Board Meeting	Hyatt Regency Ballroom West
12:00 NOON	Luncheon Meeting, Executive Committee & Reference Committee Chairmen	Atlanta Room/Hyatt
1:30 PM	Specialty Group Sessions . . . Various Meeting Rooms — Hyatt Regency/LC. (Eight Specialty Groups will meet simultanously at this time. Their programs begin on page 450.)	

Wednesday, September 28

7:30 AM	Registration	Registration Area-LC
8:30 AM	Second Scientific Session	General Sessions Area-LC
11:50 AM	President's Installation & Awards Luncheon	Patterson Ballrooms/Hyatt
2:00 PM	KMA Medical Student Section Meeting	Ballroom 4-LC
2:15 PM	Specialty Group Sessions . . . Various Meeting Rooms — LC. (Three Specialty Groups will meet simultaneously at this time. Their programs begin on page 455.)	
3:00 PM	KMA Board of Trustees Meeting & Dinner	Hyatt Suite
6:00 PM	Second Meeting, KMA House of Delegates	Hyatt Regency Ballroom

Thursday, September 29

8:00 AM	Registration	Registration Area-LC
8:30 AM	Third Scientific Session	General Sessions Area-LC
12:00 NOON	KMA Board of Trustees Luncheon Meeting	Hyatt Regency Ballroom West
1:30 PM	Specialty Group Sessions . . . Various Meeting Rooms — Hyatt Regency/LC (Eight Specialty Groups will meet simultaneously at this time. Their programs begin on page 456.)	

A 30-minute intermission has been scheduled during each morning Scientific Session and each afternoon Specialty Group Session for visiting Scientific and Technical Exhibits.

Kentucky Medical Association

Scientific Program

John Giles Cecil Meeting



Donald C. Barton, MD
KMA President, Presiding

Tuesday, September 27, 1988
Morning General Session
General Sessions Area — Lexington Center

8:30 AM Opening Ceremonies
8:40 AM **"The Role of Lumpectomy and Radiotherapy in the Treatment of Localized Breast Cancer"**
Pat J. Numann, MD, Syracuse, NY
9:00 AM **"Childhood Acute Lymphoblastic Leukemia: A Paradigm for Successful Treatment of Disseminated Cancer"**
William M. Crist, MD, Memphis, TN
9:20 AM **"Update on Prostatic Cancer"**
John J. Mulcahy, MD, Indianapolis, IN
9:40 AM **"Breast Cancer Update 1988: Are We Making Progress?"**
Paul P. Carbone, MD, Madison, WI
10:00 AM **Intermission to Visit Exhibits**
10:30 AM **"Early Detection of Primary Pelvic Malignancy in the Female Reproductive System"**
Robert Stanhope, MD, Rochester, MN
10:50 AM **"Lung Cancer: Newer Aspects"**
Bashir A. Chaudhary, MD, Augusta, GA
11:10 AM **"Breast Reconstruction After Mastectomy and Conservative Treatment"**
John Bostwick, III, MD, Atlanta, GA
11:30 AM **"Psychological Aspects of Cancer: An Update"**
Miriam Rosenthal, MD, Cleveland, OH



Patricia J. Numann, MD
Syracuse, NY

Associate Professor of Surgery, State University of New York Health Science Center, Syracuse. MD, 1965, State University of New York Health Sciences Center. Member, American College of Surgeons; American Association for Endocrine Surgery; International Association for Endocrine Surgery; Association of Women Surgeons; and AMA. Author of numerous publications.



William M. Crist, MD
Memphis, TN

Professor of Pediatrics, University of Tennessee College of Medicine, Memphis; Member and Chairman, Department of Hematology/Oncology, St. Jude Children's Research Hospital, Memphis. MD, 1969, University of Missouri, Columbia. Member, American Society of Hematology; American Society of Clinical Oncology; American Association for Cancer Research; Society for Pediatric Research; International Society of Pediatric Oncology; and American Association for the Advancement of Science. Author of numerous publications.

Ky Chapter, American College of Chest Physicians

Meeting Room C — Lexington Center
Tuesday, September 27, 1988

1:30 PM **"Lung Cancer Update"**
Bashir A. Chaudhary, MD, Augusta, GA
2:15 PM **"Management of Hypertension in the Patient with Pulmonary Disease"**
Ronald B. George, MD, Shreveport, LA
3:00 PM **Intermission to Visit Exhibits**
3:30 PM **"Thrombolytic Therapy in Acute Myocardial Infarction"**
Michael W. Rich, MD, St. Louis, MO
4:15 PM **"Non Q Wave Infarcts and Silent Ischemia"**
Morton Kern, MD, St. Louis, MO

Ky OB/GYN Society — Ky Section ACOG

Ballroom 2 — Lexington Center
Tuesday, September 27, 1988

1:30 PM **"SUI, New Developments"**
Robert Stanhope, MD, Rochester, MN
2:15 PM **"Premature Rupture of Membranes at Term"**
Joseph A. Spinnato, MD, Louisville, KY
2:45 PM **Intermission to Visit Exhibits**
3:15 PM **"Hemolytic Diseases of the Fetus"**
Joseph A. Spinnato, MD, Louisville, KY
4:00 PM **"History of Obstetrical Forceps"**
Charles R. Oberst, MD, Louisville, KY



John J. Mulcahy, MD
Indianapolis, IN

Associate Professor of Urology, Indiana University Medical Center; Chief of Urology, Wishard Memorial Hospital, Indianapolis, IN. MD, 1966, Georgetown Medical School, Washington, DC. Member, Society of University Urologists; American Urologic Association; American Fertility Society; AMA; and Fellow, American College of Surgeons. Author of numerous publications.



Paul P. Carbone, MD
Madison, WI

Director, University of Wisconsin Clinical Cancer Center; Professor, Departments of Human Oncology and Medicine, University of Wisconsin, Madison. MD, 1956, Albany Medical College, New York. Member, Board of Directors, National Foundation for Cancer Research; External Advisory Committee, Markey Cancer Center, University of Kentucky; American Association for Cancer Research; American Society of Clinical Oncology; and Governor, Wisconsin Chapter, American College of Physicians. 1987 recipient of the Medal of Honor for Critical Research, American Cancer Society. Editorial Board, *Medical and Pediatric Oncology*, *Cancer Clinical Trials*, and *Journal of Clinical Oncology*. Author of numerous publications.

Ky Pediatric Society

Ballroom 3 — Lexington Center
Tuesday, September 27, 1988

1:30 PM **"The Genetics of Childhood Cancers: Implications in Pathogenesis and Treatment"**
William M. Crist, MD, Memphis, TN
2:15 PM **"Long Term Follow-up of Survivors of Childhood Malignancy"**
John D. Geil, MD, Lexington, KY
2:45 PM **Intermission to Visit Exhibits**
3:15 PM **"Current Approach to Diagnosis and Treatment of Anorexia and Bulemia"**
Laurie L. Humphries, MD, Lexington, KY
3:45 PM **"Newly Recognized Pathogens in Gastrointestinal Disease in Infants and Children"**
Gerard P. Rabalais, MD, Louisville, KY
4:30 PM Business Meeting

Ky Chapter, American College of Physicians

Meeting Rooms A & B — Lexington Center
Tuesday, September 27, 1988

1:30 PM **"Cancer in the Elderly: To Treat or Not To Treat"**
Paul P. Carbone, MD, Madison, WI
2:00 PM **"Future Use of Autologous Bone Marrow Transplantation in Solid Tumors"**
Peggy J. Henslee, MD, Lexington, KY
2:20 PM **"Biological Response Modifiers Using Interferon in Treatment of Hairy Cell Leukemia"**
John Neefe, MD, Lexington, KY
2:40 PM **Intermission to Visit Exhibits**
3:10 PM **"Decision Making in Breast Cancer for the Internist"**
Edward Romond, MD, Lexington, KY
3:30 PM **"Combined Modality Treatment in GI Malignancies"**
John Cronin, MD, Lexington, KY
3:50 PM **"The Newer Uses of Chemotherapy"**
John S. MacDonald, MD, Lexington, KY



C. Robert Stanhope, MD
Rochester, MN

Associate Professor, Gynecologic Surgery, Mayo Clinic, Rochester. MD, 1968, Medical College of Wisconsin, Milwaukee. Member, American Association of Pro Life Obstetricians and Gynecologists; American College of Surgeons; American Society of Clinical Oncology; and AMA. Author of numerous publications.



Bashir A. Chaudhary, MD
Augusta, GA

Associate Professor of Medicine and Professor of Allied Health, Medical College of Georgia, Augusta. Medical Degree, 1970, King Edward Medical College, Lahore, Pakistan. Fellow, American College of Chest Physicians and American College of Physicians. Member, American Thoracic Society; American Federation of Clinical Research; Southern Medical Association; AMA; and President, American College of Chest Physicians, Southern. Reviewer, *Chest; Journal of the Southern Medical Association*; and *Journal of the Islamic Medical Association of North America*. Author of numerous publications.

Ky Society for Plastic & Reconstructive Surgery

Meeting Room E & F — Lexington Center
Tuesday, September 27, 1988

1:30 PM **"Plagiocephaly"**
Henry Vasconez, MD, Lexington, KY
1:45 PM **"To Be Announced"**
U of L Resident Paper
2:00 PM **"Mycobacterium Infection Case Reports and Review of Literature"**
Phillip Blevins, MD, Lexington, KY
2:15 PM **"To Be Announced"**
U of K Resident Paper
2:30 PM **Intermission to Visit Exhibits**
3:00 PM **"Update on Breast Reconstruction"**
John Bostwick, III, MD, Atlanta, GA
3:30 PM **"To Be Announced"**
U of K Resident Paper
3:45 PM **"Urogenital Reconstruction"**
Richard Sadove, MD, Lexington, KY
4:00 PM **"To Be Announced"**
U of L Resident Paper

Ky Psychiatric Association

Patterson Ballroom A — Hyatt Regency Hotel
Tuesday, September 27, 1988

1:30 PM **"Depression During Pregnancy: Mood Disorders in Pregnancy and Postpartum"**
Miriam Rosenthal, MD, Cleveland, OH
2:30 PM **"Management of Pain in Cancer Patients"**
Lesley Dickson, MD, Lexington, KY
3:00 PM **Intermission to Visit Exhibits**
3:30 PM **"Psychoneuroimmunology — An Update"**
Clifford Kuhn, MD, Louisville, KY



John Bostwick, MD
Atlanta, GA

Professor of Surgery, Division of Plastic Surgery, Department of Surgery, Emory University School of Medicine; Partner, the Emory Clinic, Atlanta. MD, 1966, University of Tennessee College of Medicine, Memphis. Member, American Society of Plastic and Reconstructive Surgeons; American Association of Academic Plastic Surgeons; American Society of Aesthetic Plastic Surgery; AMA; Fellow, American College of Surgeons; and Member, Board of Trustees, American Association of Plastic Surgeons. Author of numerous books and publications.



Gregory J. Renner, MD
Columbia, MO

Associate Professor of Surgery, Division of Otolaryngology, University of Missouri-Columbia School of Medicine, Columbia, MO. MD, 1976, Southern Illinois University School of Medicine. Fellow, American Academy of Otolaryngology/Head and Neck Surgery; American Academy of Facial Plastic and Reconstructive Surgery; and American College of Surgeons. Member, Society of University Otolaryngologists/Head and Neck Surgeons; AMA; and the American Cancer Society. Author of numerous publications.

Ky Chapter, American College of Surgeons

Ballroom 4 — Lexington Center
Tuesday, September 27, 1988

1:30 PM Welcome
William Strodel, MD, Lexington, KY
1:35 PM **"Update on Surgical Management of Gastric Cancer"**
Patrick McGrath, MD, Lexington, KY
1:55 PM **"The Oncologist and Gastric Cancer"**
Jack McDonald, MD, Lexington, KY
2:15 PM **"Update on Esophageal Cancer"**
Martin Popp, MD, Cincinnati, OH
2:35 PM **"Radiotherapy in Rectal and Anal Cancer"**
William J. Spanos, MD, Louisville, KY
2:55 PM **"Management of Liver Metastases"**
Richard W. Schwartz, MD, Lexington, KY
3:15 PM Panel Discussion
Doctors McGrath, McDonald, Popp, Spanos, and Schwartz
3:35 PM **Intermission to Visit Exhibits**
3:45 PM **"Breast Cancer — Lumpectomy, Modified Radical and Radical Mastectomy"**
Pat J. Numann, MD, Syracuse, NY
4:15 PM **"The Oncologist and Breast Cancer"**
Edward H. Romond, MD, Lexington, KY
4:35 PM **"Update on Melanoma"**
Hiram Polk, MD, Louisville, KY
4:55 PM **"Update on Head and Neck Cancer"**
Daniel Kenady, MD, Lexington, KY
5:15 PM Panel Discussion
Doctors Numann, Romond, Polk, and Kenady

Ky Urological Association

Meeting Room D — Lexington Center
Tuesday, September 27, 1988

1:30 PM **"Management of Complications of Prosthetic Penile Surgery"**
John J. Mulcahy, MD, Indianapolis, IN
2:30 PM Pyelogram Conference
3:15 PM **Intermission to Visit Exhibits**
3:45 PM Business Meeting



Miriam Rosenthal, MD
Cleveland, OH

Associate Professor, Psychiatry and Reproductive Biology, Case Western Reserve University, Cleveland. MD, 1953, George Washington University, Washington, DC. Past President, American Society for Psychosomatic Obstetrics and Gynecology; and Fellow, American Psychiatric Association. Member, Association of American Medical Colleges, Central Group on Student Affairs; American Psychosomatic Association; American Psychiatric Association; and Liaison, American College of Obstetrics and Gynecology. Editorial Board, *Journal of Psychosomatic Obstetrics and Gynecology* and *Advances in Psychosomatic Medicine*. Author of numerous publications.



Noel S. Weiss, MD
Seattle, WA

Professor and Chairman, Department of Epidemiology, School of Public Health and Community Medicine, University of Washington; Member, Fred Hutchinson Cancer Research Center, Seattle. MD, 1967, Stanford University, California. Author of numerous publications.

James A. Baumgarten, MD
Chairman, Scientific Program Committee, Presiding

Wednesday, September 28, 1988
Morning General Session
General Sessions Area — Lexington Center

8:30 AM Announcements
8:40 AM **"Role of the Family Physician With the Cancer Patient's Family"**
Martin Raber, MD, Houston, TX
9:00 AM **"Endometrial Cancer in Users of Postmenopausal Estrogens: Can and Should it be Prevented With Progestogens?"**
Noel Weiss, MD, Seattle, WA
9:20 AM **"Carcinogens in the Workplace"**
Roy Albert, MD, Cincinnati, OH
9:40 AM **"Features and Factors Influencing the Prognosis of Cancer: the Pathologist's Role in a Time of Clinical Information Gathering"**
Louis P. Dehner, MD, Minneapolis, MN
10:00 AM **Intermission to Visit Exhibits**
The following presentors will each be speaking on, "The Ethics of Death & Dying"
10:30 AM William C. DeVries, MD, Louisville, KY
10:50 AM Russel H. Patterson, Jr., MD, Chicago, IL
11:10 AM Andrew H. Malcolm, New York, NY
11:30 AM Questions and Answers
11:50 AM President's Installation & Awards Luncheon

President's Installation & Awards Luncheon

Patterson Ballrooms
Hyatt Regency Lexington

Donald C. Barton, MD
KMA President, presiding

Invocation
Recognition

Guest Speaker

The Honorable Brereton C. Jones
Kentucky's Lieutenant Governor

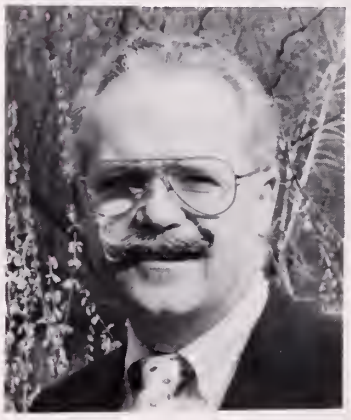
Awards Presentation
S. Randolph Scheen, MD, Louisville
Chairman, KMA Awards Committee

Installation of new KMA President



Roy E. Albert, MD
Cincinnati, OH

Professor of Environmental Health and Chairman, Department of Environmental Health and the Kettering Laboratory, University of Cincinnati Medical Center, University of Cincinnati; Chairman, Carcinogen Assessment Group, US Environmental Protection Agency. MD, 1946, New York University College of Medicine. Member, American Association for the Advancement of Science; American Association for Cancer Research; American College of Toxicology; Society for Epidemiologic Research; and Society for Occupational and Environmental Health. Author of numerous publications.



Andrew H. Malcolm
New York, NY

First Assistant National Editor, *The New York Times*. MA in Journalism, 1967, Northwestern University. Author of several books including *This Far and No More* which became an NBC TV *Movie of the Week* titled *Right to Die*. Recipient of several major awards for national reporting.

Ky Chapter, American Academy of Family Physicians

Ballroom 2 — Lexington Center
Wednesday, September 28, 1988

2:15 PM **"Cancer Screening and Early Detection"**
Martin Raber, MD, Houston, TX
3:00 PM Panel Discussion

Ky Occupational Medical Association

Ballroom 3 — Lexington Center
Wednesday, September 28, 1988

2:15 PM **"Update on Beryllium"**
Roy Albert, MD, Cincinnati, OH
3:00 PM **"Public Health and the Occupational Physician"**
David Allen, MD, Louisville, KY
3:30 PM **Intermission to Visit Exhibits**
4:00 PM Business Meeting

Ky Society of Pathologists

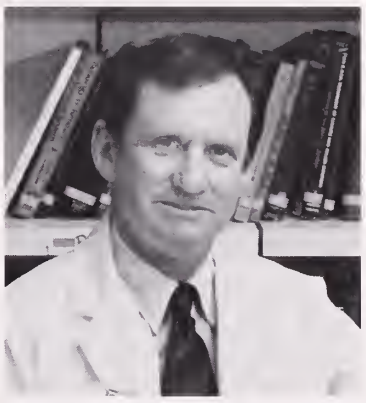
Meeting Rooms A & B — Lexington Center
Wednesday, September 28, 1988

2:15 PM **"Breast Pathology — The Spectrum of Typical, Atypical and Overtly Malignant Lesions"**
Louis P. Dehner, MD, Minneapolis, MN
3:00 PM **Intermission To Visit Exhibits**
3:30 PM **"Soft Tissue Tumors in Children — The Known and the Unknown"**
Louis P. Dehner, MD, Minneapolis, MN
4:15 PM Business Meeting



William C. DeVries, MD
Louisville, KY

Cardiovascular Surgeon and Principal Investigator for the Total Artificial Heart Project, Humana Hospital Audubon, Louisville; the singular surgeon certified by the Food and Drug Administration to implant the pneumatic artificial heart for permanent life support. MD, 1970, University of Utah College of Medicine, Salt Lake City. Author of numerous publications.



Russel H. Patterson, Jr, MD
New York, NY

Vice-Chairman, AMA Council on Ethical and Judicial Affairs; Professor of Neurosurgery, New York Hospital — Cornell Medical Center. MD, 1952, Cornell University Medical College, Ithaca, New York. Diplomate, American Board of Neurological Surgery; and President-Elect, Society of Neurological Surgeons. Formerly: President, American Association of Neurological Surgeons and American Academy of Neurological Surgery; member, Steering Committee of AMA Task Force on Health Policy Agenda for the American People; Delegate from American Association of Neurological Surgery to AMA. Author of numerous publications.

Nelson B. Rue, MD
KMA Vice President, Presiding

Thursday, September 29, 1988
Morning General Session
General Sessions Area — Lexington Center

8:30 AM Announcements
8:40 AM **"Histamine H_2 Antagonists as Immunoenhancers in Patients With Immunodeficiency/Malignancy"**
Ross Rocklin, MD, Boston, MA
9:00 AM **"Diagnosis and Treatment of Unusual Skin Malignancies in the Head and Neck"**
Greg Renner, MD, Columbia, MO
9:20 AM **"Perioperative Use of Colonoscopy in the Management of Colorectal Carcinoma"**
Theodore R. Schrock, MD, San Francisco, CA
9:40 AM **"Selected Advances in the Management of Ophthalmic Tumors"**
Jerry A. Shields, MD, Philadelphia, PA
10:00 AM **Intermission to Visit Exhibits**
10:30 AM **"The Management of Chronic Pain"**
Phulchand Prithvi Raj, MD, Houston, TX
10:50 AM **"Current Concepts in the Diagnosis and Therapy of Melanoma"**
David N. Silvers, MD, New York, NY
11:10 AM **Topic & Speaker To Be Announced**
11:30 AM **"Diagnostic Dilemmas in Lung Lesions"**
Faxon Payne, MD, Nashville, TN
11:50 AM **"Limb Salvaging Surgery for Musculoskeletal Sarcomas"**
William F. Enneking, MD, Gainesville, FL

Ky Society of Allergy & Clinical Immunology

Meeting Rooms A & B — Lexington Center
Thursday, September 29, 1988

1:30 PM **"Current Research Interests"**
Ross Rocklin, MD, Boston, MA
2:40 PM **"Topic To Be Announced"**
Robert Coutant, MD, Louisville, KY
3:15 PM **"The URI Redefined"**
Erwin Jones, MD, Lexington, KY
4:00 PM Business Meeting



Theodore R. Schrock, MD
San Francisco, CA

Professor of Surgery, University of California School of Medicine, San Francisco. MD, 1964, University of California School of Medicine. President, Society of American Gastrointestinal Endoscopic Surgeons; Past President, American Society for Gastrointestinal Endoscopy; Fellow, American College of Surgeons and International Society of University Colon and Rectal Surgeons; member, International Society of Surgery and AMA. Reviewer, *New England Journal of Medicine, Western Journal of Medicine*, and *American Journal of Gastroenterology*. Editorial Board, *Surgical Endoscopy, Ultrasound and Interventional Techniques*. Author of numerous publications.



William F. Enneking, MD
Gainesville, FL

Distinguished Service Professor and Eugene L. Jewett Professor of Orthopaedic Surgery, University of Florida College of Medicine. MD, 1949, University of Wisconsin, Madison. Member, American Academy of Orthopaedic Surgeons; Past President of the Orthopaedic Research Society and the American Orthopaedic Association. Author of numerous publications.

Ky Society of Anesthesiologists

Meeting Room D — Lexington Center
Thursday, September 29, 1988

1:00 PM **"A.S.A. Update"**
Richard H. Stein, MD, Vincennes, IN
1:45 PM **"The Recent Advances in the Treatment of Pain and Pain Syndromes"**
Phulchand Prithvi Raj, MD, Houston, TX
2:30 PM **Intermission to Visit Exhibits**
3:00 PM **"Management of Cancer Pain"**
Theresa Brechner, MD, Los Angeles, CA
3:45 PM **"Pharmacology of Anesthetics in Aged Patients"**
Bradley Smith, MD, Nashville, TN
4:30 PM **"Recent Advances in Intravenous Anesthesia Alfentanil: Pharmacology and Clinical Uses"**
Michael Goldberg, MD, Churchville, PA
5:15 PM **"Anesthesia and the Patient with AIDS"**
Ernest R. Greene, Jr, MD, PhD, Birmingham, AL

Ky Dermatological Society

Lexington Clinic East — 100 North Eagle Creek Road — Lexington
Thursday, September 29, 1988

1:30 PM Viewing of Case Presentations
2:30 PM Break
3:00 PM **"Discussion of Case Presentations"**
David N. Silvers, MD, New York, NY

Ky Academy of Eye Physicians and Surgeons

Ballroom 4 — Lexington Center
Thursday, September 29, 1988

1:30 PM **"To Be Announced"**
Presentation of Papers by Members of Ky Academy of Eye Physicians and Surgeons
2:00 PM **"The Management of Malignant Intraocular Tumors"**
Jerry A. Shields, MD, Philadelphia, PA
2:30 PM **Intermission to Visit Exhibits**
3:00 PM **"To Be Announced"**
Presentation of Papers by Members of Ky Academy of Eye Physicians and Surgeons
3:30 PM **"Update on the Diagnosis and Management of Orbital Tumors"**
Jerry A. Shields, MD, Philadelphia, PA
4:00 PM Business Meeting



Ross E. Rocklin, MD
Boston, MA

Chief, Allergy Division, New England Medical Center Hospital; Professor of Medicine, Tufts University School of Medicine, Boston. MD, 1966, Howard University, Washington, DC. Member, American Federation for Clinical Research; American College of Physicians; American Association for Clinical Immunology and Allergy; American Association of Physicians. Editorial Board, *Journal of Clinical Immunology and Immunopathology; Journal of Immunological Methods; Cellular Immunology*; Section Editor, *Manual of Clinical Immunology*; Editor, *Clinical Immunology Review Journal*; and Co-Editor, *International Journal of Immunotherapy*. Author of numerous publications.



W. Faxon Payne, MD
Nashville, TN

Clinical Professor of Radiology and Radiological Sciences, Vanderbilt University School of Medicine, Nashville. MD, 1948, Vanderbilt University School of Medicine. Member, Radiological Society of North America; Society of Nuclear Medicine; American Institute of Ultrasound in Medicine; KMA; and Fellow, American College of Nuclear Medicine. Editorial Advisor, *American Health Magazine.*

Ky Society for Gastrointestinal Endoscopy

Ballroom 3 — Lexington Center
Thursday, September 29, 1988

1:30 PM **"Colonoscopy in the Management of Emergency Colorectal Diseases"**
Theodore R. Schrock, MD, San Francisco, CA

2:30 PM **Intermission to Visit Exhibits**

3:00 PM **"Reflux Esophagitis"**
Stephen A. McClave, MD, Louisville, KY

3:15 PM **"Screening for Colon Cancer Using Flexible Sigmoidoscopy"**
Richard J. Mullins, MD, Louisville, KY

3:30 PM **"Control Study of Sclerotherapy Agents"**
Stephen A. McClave, MD, Louisville, KY

3:45 PM **"Medical Therapy of Achalasia"**
Richard A. Wright, MD, and Ben Cecil, MD, Louisville, KY

4:00 PM **"Choledochoscopy and Common Bile Duct Exploration: A Local Experience"**
Brent Wheeler, MD, Louisville, KY

4:15 PM **"The Meaningful Yield of Colonoscopy in Patients With Heme Positive Stools"**
Mark Spurlin, MD, Lexington, KY

Ky Orthopedic Society

Meeting Room C — Lexington Center
Thursday, September 29, 1988

1:30 PM **"Short Term Follow-Up of Uncemented Total Hip Replacement"**
Walter E. Badenhausen, MD and Donald L. Pomeroy, MD, Louisville

1:50 PM **"Proximal Femoral Bulk Allografts — Short Term Follow-Up"**
Walter E. Badenhausen, MD and Donald L. Pomeroy, MD, Louisville

2:10 PM **"Prophylactic Management of Open Fractures With Antibiotic Bead Pouch Technique"**
Steven L. Henry, MD, Louisville

2:30 PM **"Staging of Musculoskeletal Lesions"**
William F. Enneking, MD, Gainesville, FL

3:00 PM **Intermission to Visit Exhibits**

3:30 PM **"Brachial Plexus"**
Tsu-Min Tsai, MD; Suminori Kanaya, MD; Mark Gonzalez, MD; and Chong Min Park, MD, Louisville

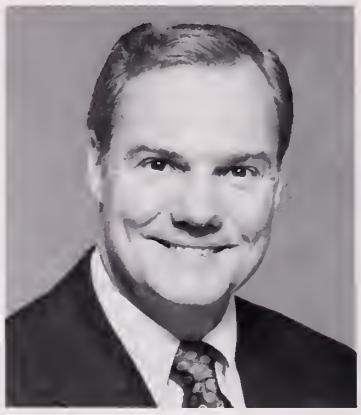
3:45 PM **"Vascularized Joint Transfer"**
Paul Ellis, MD; Tsu-Min Tsai, MD; and Donald Hanna, MD, Louisville

4:00 PM **"Replantation Variables"**
Yuka Maki, MD; Tsu-Min Tsai, MD; and Mark Brenner, MD, Louisville

4:15 PM **"Status of Orthopedic Surgery in Kentucky"**
John R. Allen, MD, Lexington

4:30 PM Business Meeting

6:30 PM Dinner — Lafayette Club



Jerry A. Shields, MD
Philadelphia, PA

Director, Oncology Service, and Attending Surgeon, Retina Service, Wills Eye Hospital, Philadelphia; Professor of Ophthalmology, Thomas Jefferson University, Philadelphia. MD, 1964, University of Michigan Medical School, Ann Arbor. Member, American Academy of Ophthalmology; AMA; American Association of Ophthalmic Pathologists; and Fellow, American College of Surgeons. Editorial Board, *Retina; International Ophthalmology; American Journal of Ophthalmology; Graefe Archives of Ophthalmology;* and *Electronic Eye Journal*. Author of numerous publications.



David N. Silvers, MD
New York, NY

Associate Clinical Professor of Dermatology and Pathology; Director, Section of Dermatopathology, College of Physicians and Surgeons, Columbia University, New York. MD, 1968, Duke University, Durham, NC. Fellow, American Academy of Dermatology; American Federation for Clinical Research; American Society of Dermatopathology; Society of Investigative Dermatology; and Member, The American College of Physicians. Author of numerous publications.

Ky Society of Otolaryngology Head & Neck Surgery, Inc.

Ballroom 2 — Lexington Center
Thursday, September 29, 1988

1:30 PM **"Moh's Therapy of Skin Malignancy"**
Michael McCall, MD, Louisville
2:15 PM **"Reconstruction of Post-Skin Cancer Excision Defects"**
Gregory Renner, MD, Columbia, MO
3:00 PM **Intermission to Visit Exhibits**
3:30 PM **"Update: Melanoma Diagnosis and Treatment"**
Gregory Renner, MD, Columbia, MO
4:00 PM To Be Announced
Resident's Paper — U of L
4:30 PM **"Passive and Active Marketing in Otolaryngology and Facial Plastic Surgery"**
Panel Discussion — S. Randolph Waldman, MD, Lexington; Gerald G. Edds, MD, Owensboro; and Donn Chatham, MD, Louisville
5:00 PM Business Meeting

Ky Association of Public Health Physicians

Isaac Scott Hathaway Room — Hyatt Regency
Thursday, September 29, 1988

1:30 PM **"How Many Kinds of Epidemiology Are There?"**
Noel Weiss, MD, Seattle, WA
2:30 PM **Intermission to Visit Exhibits**
3:00 PM Business Meeting



Phulchand Prithvi Raj, MD
Houston, TX

Director, Pain Control Center and Professor, Department of Anesthesia, Hermann Hospital and University of Texas Health Sciences Center, Houston. MBBS, 1958, Government Medical College, Mysore, India. Member, American Pain Society; American Society of Anesthesiologists; International Anesthesia Research Society; International Association for the Study of Pain; and Past President, American Society of Regional Anesthesia. Editorial Board, *Current Reviews in Clinical Anesthesia*. Author of numerous publications.



Martin N. Raber, MD
Houston, TX

Associate Professor of Medicine, Division of Medicine, The University of Texas M.D. Anderson Cancer Center; Chief, Section of General Oncology, Department of Medical Oncology, M.D. Anderson Hospital and Tumor Institute, Houston. MD, 1975, Catholic University of Louvain, Belgium. Fellow, American College of Physicians and Royal College of Physicians of Canada. Member, American Society of Clinical Oncologists; American Association for Cancer Research; and the Texas Medical Association Committee on Cancer. Editorial Board, *The Medicine Group Publications, Oncology and Biotechnology News*. Author of numerous publications.



Louis P. Dehner, MD
Minneapolis, MN

Professor of Laboratory Medicine and Pathology, and Pediatrics; Director of Anatomic Pathology, University of Minnesota Medical School, Minneapolis. MD, 1966, Washington University School of Medicine, St. Louis. Member, International Academy of Pathology; Society for Pediatric Pathology; International Society of Gynecological Pathologists; American Association of Pathologists; and Fellow, College of American Pathologists. Editorial Board, *The American Journal of Pediatric Hematology/Oncology; Perspectives in Pediatric Pathology; Pediatric Pathology; American Journal of Surgical Pathology; Archives of Laboratory Medicine and Pathology; Modern Pathology*; and Review Board, *United States and Canadian Academy of Pathology, Inc.* (International Academy of Pathology). Author of numerous publications.

NOTE: Due to a conflict with their national meetings, the Kentucky Neurosurgical Society and the Kentucky Chapter, American College of Emergency Physicians will not be meeting during KMA's Annual Meeting this year.

CONTINUING MEDICAL EDUCATION

The Kentucky Medical Association has applied for certification of the 1988 KMA Annual Meeting. It is anticipated that the program will be certified for 18½ hours of AMA Category 1 credit. This represents the maximum number of hours it is possible for a physician to earn through attendance at the Annual Meeting. CME credit is earned on an hour-for-hour basis.

In order to qualify for credit, the physician must confirm attendance at each individual meeting — General Sessions and specialty group meetings — by signing CME registration forms which will be made available through the presiding officers. (Please note that this requirement is not satisfied by signing in at KMA's general Registration area.) If you have any questions, please contact the Headquarters Office.

General Sessions Summaries

Carcinogens in the Workplace

Roy E. Albert, MD

This presentation will focus on current approaches to the risk assessment of occupational carcinogens. The strengths and weaknesses of the current methods will be discussed with illustrative examples.

Breast Reconstruction After Mastectomy and Conservative Treatment

John Bostwick, III, MD

This presentation will discuss the general background and perspective of breast reconstruction. The timing of breast reconstruction will be mentioned. Immediate reconstruction is appropriate when there is an established team consisting of a general surgeon and plastic surgeon who are familiar with these techniques. Most breast reconstructions are done at a time after the mastectomy after adjunctive treatment has been performed. The types of breast reconstruction range from use of breast implants under the available skin to tissue expansion and flaps. The most commonly used flap for breast reconstruction is the lower abdominal (TRAM) flap. This provides breast reconstruction utilizing the lower abdominal tissues so that a breast implant is not necessary. Nipple areola reconstruction is usually done at a second procedure.

After conservative treatment of breast cancer, there are a group of patients who have internal derangement and deformity. In addition, there are a group of women who have a recurrence of breast cancer, necessitating a mastectomy. Breast reconstruction in these post-radiation patients is more difficult and usually requires a TRAM flap. It is also psychologically devastating for this group of women and their management is quite complex.

Breast Cancer Update 1988: Are We Making Progress?

Paul P. Carbone, MD

Over the past 25 years the management of breast cancer has not been associated with major improvements in survival or decreases in annual incidence rates. More than 135,000 women will be diagnosed with breast cancer in 1988 and about 40,000 will die of the disease.

What is new?

The past 25 years have seen major developments as follows:

1) Acceptance of minimal surgery as a safe method of treatment.
2) Use of adjuvant systemic therapy after primary modalities.
3) Inclusion of tamoxifen as a major hormonal agent.
4) Effectiveness of mammography as a screening modality.

These advances are small, steady steps in the progress in controlling this disease rather than single large breakthroughs. More women are not being cured with minimal surgery, but the ability to effectively control the local disease without a mastectomy has encouraged women to seek attention earlier. Adjuvant chemotherapy has improved the overall survival (S) and the disease free survival (DFS) for premenopausal women with involved axillary nodes. Postoperative administration of tamoxifen in postmenopausal stage II patients has also impacted on disease free survival and survival in some studies. These gains are not large but have resulted in 15% to 25% improvement in the statistics. Recent studies have examined the role of the duration of adjuvant therapy. Information from these trials has indicated chemotherapy effects can be seen after only six months of administration that are comparable to 12 months. Tamoxifen administration appears to require continued ingestion of five or more years.

Hormonal therapy use remains a mainstay in the management of metastatic patients. The use of the estrogen receptor measurement as well as the introduction of tamoxifen has changed radically the sequence and kinds of hormone therapies. Surgical ablation of the adrenals and/or pituitary have become things of the past. Drugs can now block the estrogen receptor or inhibit adrenal production of estrogens or pituitary output of gonadotrophins. Tamoxifen has become the major hormonal therapy in breast cancer.

Mammography has been shown to significantly decrease the mortality of women who use this as a screening practice on a yearly or triannual basis. The improvement in survival is about 30%. Unfortunately many women do not use mammography regularly.

What promise does the future hold? Laboratory studies indicate that growth factors and hormonal regulation are integrated. Controlling both autocrine and endocrine factors may be important in regulating cancer cell growth. Prevention of breast cancer in laboratory animals is possible by administering tamoxifen to animals after the chemical initiation of cancer occurs. Currently a pilot study is in progress to test the

feasibility of giving tamoxifen to high risk normal women.

In sum, we are making progress. More women are living more comfortably and living longer without disease. Survival improvement is occurring with the use of adjunctive therapies and screening mammography. Potentially important leads are coming from the lab and being tested in the clinic.

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Childhood Acute Lymphoblastic Leukemia: A Paradigm for Successful Treatment of Disseminated Cancer

William M. Crist, MD

Overall, approximately 60% to 70% of newly diagnosed children with ALL are presently curable with modern treatment compared to less than 5% in 1970. Further remarkable progress in our understanding of the immunobiology, cytogenetic features and potential molecular pathogenetic mechanisms of the childhood acute lymphoid leukemias has occurred in recent years. Studies of the expression of certain lineage restricted molecules on the surface or within normal lymphoid cells and their malignant counterparts has led to an impressive improvement in our knowledge of normal B- and T-cell maturation and function, and markedly improved the classification of the diseases called ALL. These studies have revealed a biologic heterogeneity previously unsuspected and shown that there are a number of immunophenotypic species of ALL. Some of these species of ALL differ in their clinical and cytogenetic features, as well as in their curability with modern treatment, underscoring the clinical relevance of such studies. A consideration of all of these features of ALL permits a more accurate assessment of prognosis in newly diagnosed children and has permitted tailoring of therapy based on expected relapse hazard.

Cytogenetic studies have recently revealed that structural abnormalities are present in the leukemic cells of most children with ALL. Furthermore, such studies have demonstrated the presence of a number of non-random structural anomalies of chromosomes, some of which are specific for certain immunophenotypic species of ALL. Finally, molecular studies of some of these particularly informative cytogenetic anomalies in ALL cells have revealed that oncogenes may be altered and/or activated as a consequence of structural chromosomal rearrangement. These studies offer the exciting possibility that the molecular pathogenetic mechanisms leading to the immortalization of the malignant cells in ALL will be found. For the physician caring for these patients, all of this exciting new information raises the possibility that once the specific pathogenetic mechanisms of these disorders are known, more rational, less toxic, and more effective therapies will be developed.

Limb Salvaging Surgery for Musculoskeletal Sarcomas

William F. Enneking, MD

In the past 15 years, the portion of patients who present with musculoskeletal sarcomas amenable to limb salvaging surgical management has risen from 33% to 66%. This has been accomplished with no increase risk of local recurrence and with improved survival rates. This dramatic improvement in both the oncologic and functional outlook for these patients has been achieved by a combination of neoadjuvant chemotherapy, improvements in radiographic imaging, the development of a surgical staging system, and improvements in both resection technique and reconstructive technology.

Features and Factors Influencing the Prognosis of Cancer: the Pathologist's Role in a Time of Clinical Information Gathering

Louis P. Dehner, MD

The discussion will highlight the role of the surgical pathologist in the utilization of past, present, and hopefully future techniques, procedures, and observations to assist the clinician in the staging and future management of the patient with cancer. In the past few years, it has become increasingly apparent that simple histologic grading of a malignancy, determining adequacy of surgical margins and ascertaining lymph node involvement at best provides an incomplete portrait for prognostic assessment.

Update on Prostatic Cancer

John J. Mulcahy, MD

This presentation will include a brief introduction to the diagnosis and staging of prostate cancer, with emphases on newer modalities such as the use of transrectal ultrasound of the prostate and prostate specific antigen. The talk will conclude with a discussion of the current trends in treatment including radical prostatectomy versus irradiation for the treatment of curative prostate cancer, and the use of the nerve sparing technique of radical prostatectomy to preserve potency in the majority of patients. A brief comment on some of the latest chemotherapeutic agents will also be given.

Breast Cancer — The Role of Lumpectomy and Radiotherapy in the Treatment of Localized Breast Cancer

Patricia J. Numann, MD

This presentation will review the current understanding of the role of lumpectomy in the treatment of Stage I and Stage II carcinoma of the breast, the benefits of lumpectomy as opposed to modified radial mastectomy, and will identify Doctor Numann's own impressions of the benefits as well as the potential risks and contraindications of this procedure.

The Ethics of Death and Dying

Russel H. Patterson, Jr, MD

Terminating Life Supports: Which ones? When? By whom? Ethical aspects of withholding or withdrawing life sustaining treatment will be examined.

Diagnostic Dilemmas in Lung Lesions

W. Faxon Payne, MD

This presentation will include some chest cases which have a proven diagnosis of one thing, but which look very much like something else to demonstrate that things are not always what they seem.

Histamine H2 Antagonists as Immunoenhancers in Patients with Immunodeficiency/Malignancy

Ross E. Rocklin, MD

Histamine and other mediators of immediate hypersensitivity are known to have proinflammatory characteristics which are responsible for producing the various manifestations of allergic disease. Equally important is the potential role that histamine may play as an immunomodulator of lymphocyte function in vitro. Since histamine receptors on immunocytes are non-randomly distributed, depending on the sub-population of cells studied and their state of maturation, a variety of effects can be observed. Thus, histamine has been shown to inhibit antigen- and mitogen-induced T cell proliferation, lymphokine production, T helper cell function, cytotoxicity, and antibody/immunoglobulin production. Many of these effects are mediated, at least in part, via suppressor T cells that express histamine type-2 (H_2) receptors. A complex set of cellular interactions between suppressor T cells and monocytes are triggered by histamine resulting in negative regulation of T and B cell functions.

Since specific H_2 receptor antagonists can interfere with the above cellular interactions, the potential for their use as immunomodulators is considerable. A large number of in vivo and in vitro studies carried out in animals and man substantiate this hypothesis to varying degrees. Thus, the administration of H_2 antagonists in vitro will block suppressor T cell activity and allow the expression of various T and B cells functions. In addition, the administration of H_2 antagonists in vivo can result in augmentation of cutaneous delayed-type hypersensitivity reactions, increases in antibody production, correction of immune function in some immunosuppressed patients, and in reduction of tumor burden. Whether or not these diverse immunologic effects ascribed to cimetidine can be safely attributed to its ability to occupy H_2 receptors on suppressor cells, or whether they are due to

other mechanisms, is not yet resolved. Nevertheless, there is a growing body of data which suggests that H_2 antagonists such as cimetidine in the proper clinical settings may play a useful role as immunopharmacologic agents.

Psychological Aspects of Cancer: An Update

Miriam B. Rosenthal, MD

Improved prognosis for many cancer patients has made the quality of life an increasingly important issue for the management of persons with malignant disease. The recognition and treatment of psychological disorders, especially depression, will be discussed.

Perioperative Use of Colonoscopy in the Management of Colorectal Carcinoma

Theodore R. Schrock, MD

Colonoscopy is an essential tool in the diagnosis of colorectal carcinoma. Colonoscopy is the preferred method of investigating occult or gross rectal bleeding. If barium enema examination is done instead, colonoscopy is required to confirm that the radiographic lesion is indeed carcinoma and to search for synchronous polyps and cancers. Occasionally, colonoscopy is required during an operative procedure if an obstructing distal lesion prevented this examination preoperatively. Postoperative surveillance for recurrent carcinoma, metachronous carcinoma, and polyps is an important part of management.

Current Concepts in the Diagnosis and Therapy of Melanoma

David N. Silvers, MD

During the past 20 years we have learned to recognize the subtle clinical features of in situ and superficially invasive primary cutaneous melanoma. By doing so we have been able to remove countless numbers of lesions which ultimately would have become deeply invasive melanomas with a high probability of metastasizing. We have identified a subset of persons at risk for developing melanoma enabling us to undertake strategies for protecting such individuals. We have also characterized a group of benign lesions which clinically and/or pathologically simulate melanoma. The recognition of these lesions has reduced misdiagnosis and over zealous therapy.

Several randomized prospective studies of primary cutaneous melanoma have confirmed the overwhelming importance of tumor thickness and depth of tumor invasion of the primary lesion in regard to ultimate prognosis. These studies have also cast doubt as to the benefit of *wide* excision and prophylactic regional lymph node resection.

The role of chemotherapy and immunotherapy in the treatment of melanoma will be discussed.

Early Detection of Primary Pelvic Malignancy in the Female Reproductive System

C. Robert Stanhope, MD

In gynecologic oncology, prolonged disease-free survival, remission, or, at best, cure is dependent upon early diagnosis. The use of the cytobrush along with the Papanicolaou smear for the detection of early cervical cancer has been advanced as a technique superior to others and will be discussed. The identification of patients at risk for endometrial cancer and endometrial sampling in an outpatient setting is critical in the early detection of endometrial cancer, and old principles and new techniques will be addressed. Finally, an awareness of pelvic pathology on examination of the adnexa will aid in the early diagnosis of ovarian cancer. If examination cannot be adequately completed due to obesity, uterine enlargement, or any other reason, high resolution pelvic ultrasonography has been demonstrated to be very helpful in discerning which patient needs diagnostic laparoscopy or exploratory laparotomy. These and other aspects of the detection of primary genital malignancy will be presented.

Endometrial Cancer in Users of Postmenopausal Estrogens: Can and Should it be Prevented with Progestogens?

Noel S. Weiss, MD

Postmenopausal women who take estrogens are at substantially increased risk of developing endometrial cancer. The ability of progestogen supplementation to ameliorate that increased risk has not been adequately tested in a direct way. Nonetheless, the physiologic effects of progestogens, along with their effect in reducing the incidence of endometrial hyperplasia, argues that these hormones likely can protect against some or all of the elevated risk associated with exogenous estrogens. Nonetheless, because of the uncertain effects of progestogens on the occurrence of more common and more serious conditions, notably arteriosclerotic vascular disease, it re-

mains uncertain whether this likely means of cancer prevention ought to be employed.

Lung Cancer: Newer Aspects

Bashir A. Chaudhary, MD

Lung cancer is the most common cancer of mankind. In 1987, 20% of all cancers and 36% of all cancer deaths in males were due to lung cancer. In females the cancer incidence was 11% but 20% of the cancer deaths were due to lung cancer. The lung cancer death rate has exceeded the breast cancer death rate in females. Most lung cancers are due to cigarette smoking. The prognosis of lung cancer continues to be poor. The major changes in the prevention, diagnosis, and treatment include a decrease in tobacco consumption, fiberoptic examination of the airways, ability to localize small lesions, better cytologic examination, laser therapy, and a combination of various treatment modalities.

Selected Advances in the Management of Ophthalmic Tumors

Jerry A. Shields, MD

I. GENERAL CONSIDERATIONS
(This is not intended to be a comprehensive review of the treatment of ophthalmic tumors. It is designed to point out certain pertinent clinical problems encountered by the ophthalmologist and to discuss selected recent diagnostic and therapeutic advances).

II. EYELID TUMORS
- A. Diagnostic Aspects
  1. Importance of clinical recognition
  2. Punch biopsy
  3. Fine needle aspiration biopsy
- B. Therapeutic Aspects
  1. Basal cell carcinoma
     a. Role of frozen sections
     b. Surgical approach
     c. Other treatment modalities: Radiotherapy, cryotherapy, chemosurgery, etc.
  2. Sebaceous carcinoma
  3. Others

III. CONJUNCTIVAL TUMORS
- A. Diagnostic Aspects
  1. Importance of clinical recognition
  2. Incisional vs excisional biopsy
- B. Therapeutic Aspects
  1. Conjunctival melanoma
     a. Surgical approach
     b. Role of cryotherapy
     c. Role of beta radiation

IV. ORBITAL TUMORS
- A. Diagnostic Aspects
  1. Increasing role of computerized tomography
  2. Biopsy techniques — role of fine needle aspiration biopsy
- B. Surgical approaches
  1. Biopsy for tissue diagnosis followed by radiation or chemotherapy if you suspect the following:
     a. Rhabdomyosarcoma
     b. Metastatic carcinoma
     c. Lymphoid tumors
  2. Excisional biopsy if you suspect the following:
     a. Cavernous hemangioma
     b. Benign mixed tumor of lacrimal gland
     c. Others
  3. Exenteration

V. INTRAOCULAR TUMORS
- A. Intraocular Biopsy
  1. Experience with non-ocular tumors
  2. Controversy regarding intraocular biopsy
  3. Indications
  4. Technique(s)
  5. Results
  6. Future considerations
- B. Retinoblastoma
  1. Enucleation
  2. External Irradiation
  3. Cobalt Plaque radiotherapy
  4. Photocoagulation
  5. Cryotherapy
  6. Combined Modalities
- C. Posterior Uveal Melanoma
  1. Current controversy regarding enucleation
  2. Periodic observation
  3. Photocoagulation
  4. Cobalt plaque radiotherapy
  5. Enucleation
  6. Exenteration
  7. Management of extraocular extension — specific considerations

Reference

Shields JA: *Intraocular Tumors*: Diagnosis and Management. St. Louis, Mobsy (In press).

The Ethics of Death and Dying

William C. DeVries, MD

Through the public media, the American populace is progressively becoming well educated and well informed on new therapeutic options as well as on the tough ethical and legal situations confronting the doctor/patient relationship. Now more than ever, physicians are required to contemplate the legal side of treatment and non-treatment options. In the past this concern was of a lesser priority in the delivery of care to the individual patient.

In addressing the so called *Right to Life* and *Right to Death* issues confronting terminal patients, the physician of today is in a very difficult environment. Review of legislative guidelines is as conflicting and confusing as are the varied facets of these decisions a physician is forced to make.

The course of the patients with the artificial heart points out in great detail the decisions that a physician must coerce in dealing with new therapeutic modalities, the informed patient, and the law. In view of all of the external pressures put upon the doctor/patient relationship, the physician must never lose sight of the patient as the center of the care. A sensitive doctor/patient relationship should be the guideline by which a physician should act on these difficult matters.

Role of the Family Physician in the Management of the Patient with Cancer

Martin N. Raber, MD

Given the high incidence of cancer in our society and its significant morbidity and mortality, it is not surprising that this disease has a major impact on physicians of all specialties. A comprehensive approach to the clinical problem includes programs which address screening and prevention, diagnostic evaluation, staging of disease, multimodality therapy and rehabilitation, as well as hospice and terminal care. While the actual design and delivery of treatment may be the domain of subspecialists, the role of the family physician is paramount in the areas of diagnosis, screening and primary prevention, as well as follow-up, rehabilitation and terminal care. Many practitioners often also play a major role in administering therapy under a subspecialist's direction.

Family physicians are in a unique position to influence the incidence of cancer, encouraging cancer prevention strategies in their healthy patients, as well as improve the chances of their cancer patients being cured by integrating strategies of early detection and screening into their practice. At the same time they can have a major impact on the patients natural history by close monitoring of treatment and its complications, and rehabilitation. For the patients who eventually die of their illness, the family physician may be a major resource for the family in organizing terminal care.

The Management of Chronic Pain

Phulchand Prithvi Raj, MD

The interdisciplinary approach to chronic pain offers an alternative to the traditional medical/surgical approach in that it addresses suffering as well as pain. Teamwork and coordination are likely to become more important in the future to avoid fragmentation of medical services from the current trend of increasing specialization. The interdisciplinary approach is here to stay and will continue to flourish in many university hospitals, but its role needs to be redefined. Most of the studies supporting the effectiveness of the approach deal with the well-being of a small group of select patients. Few studies address problems of managing a large number of patients in a cost-effective manner and maintaining the satisfaction of the participating clinicians. We must control cost, yet expand service. We must search for new therapeutic modalities and develop indices to measure the effectiveness of the program. We must realize that the best way to deal with chronic pain is to prevent an acute problem from becoming progressive and chronic. With continued experience, modeling, and remodeling of the program, it is believed that this approach will achieve a high index of success with rehabilitation and full activity as the ultimate obligatory goal.

1988 Technical Exhibitors

Abbott Laboratories **(12)**
Adria Laboratories **(96)**
Aetna Life and Casualty **(42)**

Baptist Hospitals, Inc. **(23)**
Becton Dickinson Primary Care Diagnostics **(16)**
Beecham Laboratories **(85)**
Berlex Laboratories, Inc. **(40)**
Blue Cross and Blue Shield of Kentucky **(38)**
Brentwood Instruments **(102)**
Bristol Laboratories **(87)**
Burroughs Wellcome Company **(79)**

CSR, Inc. **(78)**
Central Pharmaceuticals, Inc. **(94)**
Charter Hospital of Kentucky — Louisville/Lexington/Paducah **(55)**
Ciba Pharmaceutical Company **(41)**
Clayton L. Scroggins Assoc., Inc. **(13)**

Davis & Geck, American Cyanamid **(63)**
Dietary Enterprises, Ltd. **(24)**
Disability Determinations **(36)**
Dista Products Company **(80)**
Dorsey Pharmaceuticals **(53)**

Elcomp Systems, Inc. **(20)**
Electronic Data Systems Corp. **(98)**
Eli Lilly and Company **(74)**

First Kentucky Trust **(103)**
Fisons Corporation **(43)**
Frazier Rehab Center **(51)**
Future Tech Corporation **(34)**

Geigy Pharmaceuticals **(35)**
General Medical Corporation **(60)**
Gerber Products Company **(57)**
Glaxo **(2)**
Good Samaritan Hospital **(30)**
Guild of Prescription Opticians of KY **(49)**

Health Data Network **(47)**
HealthTrust, Inc. **(95)**
Hearing Aid Association of Kentucky **(19)**
Hoechst-Roussel Pharmaceuticals, Inc. **(37)**
Humana, Inc. **(58)**

ICI Pharma, Division of ICI Americas, Inc. **(17)**
Insurance Corporation of America **(89)**
International Medical Electronics, Ltd. **(82)**
Janssen Pharmaceutica **(69)**
Jewish Hospital **(32)**

KMA Insurance Agency **(66)**
KMI Medical Center **(1)**
Kentuckiana Medical Equipment **(77)**
Kentucky Army National Guard **(45,46)**
Kentucky Medical Insurance Company **(67)**
Kentucky Telco Federal Credit Union **(97)**
Knoll Pharmaceuticals **(76)**

Lakeview Rehabilitation Hospital **(100)**
Lederle Laboratories **(4)**
Lexington Diagnostic Center **(90)**
Lippincott Company, J.B. **(33)**

Marion Laboratories, Inc. **(31)**
McNeil Consumer Products Company **(92)**
McNeil Pharmaceuticals **(21)**
Mead Johnson Nutritionals **(86)**
Mead Johnson Pharmaceuticals **(88)**
Med Derm, Inc. **(25)**
Medical Equipment Designs **(84)**
Medical Management Resources **(15)**
Medical Protective Company, The **(73)**
Mednet, Inc. **(54)**
Merck, Sharp & Dohme **(93)**
Miles, Inc., Diagnostics Division **(62)**
Miles — Pharmaceutical Division **(81)**

Norton Psychiatric Clinic **(91)**

Olympus Corp **(7)**
Ortho Pharmaceutical Corporation **(9)**
Our Lady of Peace Hospital **(64)**

PCI Diagnostic Systems, Inc. **(27)**
PIE Mutual Insurance Company **(26)**
Parke-Davis **(28)**
Pfizer Laboratories **(65)**
Princeton Pharmaceutical Products **(101)**

Quality X-Ray Services, Inc. **(18)**

Ransdell Surgical, Inc. **(50)**
Rivendell of Kentucky, Inc. **(99)**
Robins Company, A. H. **(8)**
Roche Biomedical Laboratories, Inc. **(14)**
Roche Diagnostic Systems **(22)**
Roerig, J. B. **(11)**
Rorer Pharmaceuticals **(48)**

Sandoz **(52)**
Schering Corp **(61)**
Searle, G. D. & Company **(3)**
Skycare, Inc. **(75)**
Smith, Kline & French **(68)**
Southern Medical Association **(10)**
Squibb, E. R. & Sons **(56)**
Stuart Pharmaceuticals **(39)**
Syncor Parenteral Pharmacy Services **(104)**

Upjohn Company **(83)**
Upjohn Healthcare Services **(72)**
U.S. Air Force Medical Recruiting **(71)**
U.S. Army Health Professional Support Agency **(29)**

Westwood Pharmaceuticals **(70)**
Whitehall Laboratories **(44)**
Winthrop Pharmaceuticals **(59)**
Wyeth-Ayerst Laboratories **(5,6)**

Technical Exhibits

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14th and Sheridan Road
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You are cordially invited to visit the Abbott exhibit which will feature Tranxene® T-Tab™ (clorazepate dipotassium) PCE® (erythromycin particles in tablets), Ogen® (estropipate tablets, USP) and other pharmaceutical products.

Adria Laboratories **Booth 96**
PO Box 16529
Columbus, OH 43216
(614) 764-8100
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Individual Case Management, ICM for short, was pioneered by Aetna in 1982. It was developed because Aetna recognized that prolonged hospitalization was devastating to patients and their families - financially and emotionally. Basically, ICM's goal is simple: to provide more cost-effective quality alternative care for individuals facing extended hospital treatment. The alternatives include convalescent facilities, residential treatment facilities and often even a patient's own home. Individuals are automatically eligible if covered under the Aetna plan.

Baptist Hospitals, Inc. **Booth 23**
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Louisville, KY 40207
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Services of BHI hospitals will be displayed. Questions encouraged.

Becton Dickinson **Booth 16**
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Our agency prepares Social Security and Supplemental Security Income disability determinations on Kentucky applicants. The professional relations staff will be available to answer questions, explain any new disability criteria, and talk with physicians interested in performing consultative examinations on applicants across the State.

Dista Products Company **Booth 80**
Lilly Corporate Center
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(317) 276-2554
Dista Products Company welcomes the opportunity to once again participate in your exhibit program. We cordially invite you to visit our display where our professional representatives will be available to discuss any inquiries you may have regarding our products including Keftab™ (cephalexin hydrochloride monohydrate, Dista) and Nalfon® (fenoprofen calcium, Dista).

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Full line distributor meeting the needs of physicians in Kentucky. We furnish a wide variety of equipment used by physicians; i.e., chemistry analyzer, hemotology analyzer, EKG and Holter equipment, spirometers, etc. We can also meet the needs of a physician's disposable products. We are the nation's largest provider in the physician clinic market.

Gerber Products Company **Booth 57**
445 State Street
Fremont, MI 49412
(616) 928-2257
Visit our booth featuring Gerber's new FIRST FOODS™ FRUITS AND VEGETABLES as well as Gerber's other foods, Gerber and NUK nursing accessories, breast pumps and Ultrasonic humidifier. Discuss our product information and patient booklets with our medical representative.

Glaxo **Booth 2**
Five Moore Drive
PO Box 13358
Research Triangle Park, NC 27709
(919) 248-2100

Good Samaritan Hospital **Booth 30**
310 South Limestone Street
Lexington, KY 40508
(606) 252-6612, ext 3803
Good Samaritan's exhibit will focus on the Vascular Center of the Bluegrass which was established by the hospital in mid-1987. Audio visuals and printed materials will be provided concerning state-of-the-art techniques in intravascular laser surgery. The medical expertise of the Center's physician panel and the availability of related diagnostic services will also be featured.

Guild of Prescription Opticians of Kentucky **Booth 49**
640 Fourth Avenue
Louisville, KY 40202
(502) 583-0687
Guild of Prescription Opticians of Kentucky, Louisville, Kentucky (Booth No. 49). Eyeglasses adjusted - visit our booth to have your eyeglasses properly adjusted for maximum comfort and visual benefit. Minor repairs can be made on the spot. Free Distant and Near Vision test cards, for use by the general practitioner, are offered. Your Guild Optician works closely with the ophthalmologist to provide the best in visual aid appliances. Support the Eye Physician Guild Optician type of eye services for better eye care.

Health Data Network **Booth 47**
PO Box 6749
Louisville, KY 40206-0749
(502) 896-3000
Health Data Network, a company with more than 20 years of health care information systems experience, will demonstrate an online computer system for the management of patient billing and accounts receivable, accounts payable, general ledger and payroll in the physician's office. Claimsfiler, an electronic claims processing product, will be available for demonstration to physicians and their office staff.

HealthTrust, Inc. **Booth 95**
4525 Harding Road
Nashville, TN 37205
(800) 627-4484, ext 249
HealthTrust, Inc. is a hospital company with the majority of the facilities located in the southeast. Our focus for this meeting is physician recruiting and public relations for the six HealthTrust, Inc. facilities in Kentucky.

Hearing Aid Association of Kentucky **Booth 19**
120 South Pin Oak Drive
Lexington, KY 40503
(606) 278-9568

Hoechst-Roussel Pharmaceuticals **Booth 37**
Route 202-206 North
Somerville, NJ 08876
(201) 231-2727

Trental* Trental (pentoxifylline) is the first proven effective agent for the treatment of intermittent claudication symptomatic of peripheral vascular disease. Trental has been shown to improve red cell flexibility and lower blood viscosity. Stop by the Hoechst-Roussel Pharmaceuticals Inc. exhibit for more information about this exciting new treatment for intermittent claudication.

DiaBeta* From the innovators in diabetes mellitus research and the originators of sulfonylurea therapy - DiaBeta* (glyburide) has been used worldwide in over 95 countries for 14 years. Please stop by our booth to allow us to answer any of your questions about the world's most prescribed oral hypoglycemic.

Claforan* Claforan* (cefotaxime sodium) Sterile will be featured at the Hoechst-Roussel Pharmaceuticals, Inc. display. Information on Claforan's excellent record of efficacy, safety, and cost efficiency will be

provided at our booth.
*Registered

Humana, Inc. **Booth 58**
The Humana Building
500 West Main Street
Louisville, KY 40201
(502) 580-3571
Humana is an integrated health care services company that owns and operates 86 hospitals, including seven in Kentucky - Louisville (4), Lexington, Louisa, and Somerset. Physicians are needed in various specialties to join members of our medical staffs in these communities. Stop by our booth to discuss these opportunities.

ICI Pharma **Booth 17**
Division of ICI Americas, Inc.
Concord Pike & Murphy Road
Wilmington, DE 19897
(800) 456-5678

Insurance Corporation of America **Booth 89**
4295 San Felipe, Suite 300
Houston, TX 77027
(713) 871-8100
ICA markets professional liability insurance to physicians and surgeons nationwide.

International Medical Electronics **Booth 82**
2805 Main Street
Kansas City, MO 64108
(816) 221-0115
International Medical Electronics Ltd. manufacturers of sophisticated medical equipment featuring the Magnatherm shortwave diathermy with two detachable heads. Offering the ability to treat two separate areas or one area from two directions at the same time. Please stop by Booth #82 for a demonstration.

Janssen Pharmaceutica **Booth 69**
40 Kingsbridge Road
Piscataway, NJ 08854
(502) 228-5930

Jewish Hospital **Booth 32**
Physician/Hospital Development
250 East Liberty, Suite 710
Louisville, KY 40202
(502) 568-6655
Physicians in private practice are facing a radically different health care environment with ever increasing competition for patients. Jewish Hospital offers a comprehensive program to help physicians build their private practice and manage it more effectively. Some of the services provided to our physicians include: associate recruitment, advertising and public relations, office automation systems, community education and involvement, office staff seminars, market surveys, and patient communications. Information will be available describing recruitment enhancement programs.

KMA Insurance Agency **Booth 66**
8134 LaGrange Road, Suite 100
Louisville, KY 40222
(502) 429-6273

KMI Medical Center **Booth 1**
8521 LaGrange Road
Louisville, KY 40222
(502) 426-6380
KMI Medical Center, a 94-bed full-service psychiatric hospital, will be exhibiting their services including: adolescent and adult psychiatric programs, adult chemical dependency program and outpatient services.

Kentuckiana Medical Equipment **Booth 77**
P.O. Box 6734
Louisville, Kentucky 40206
(502) 895-1059 (800) 234-5633
We will be displaying physical therapy modalities and custom/molded orthopaedic supports.

Kentucky Army National Guard **Booths 45-46**
Recruiting & Retention
Boone National Guard Center
Frankfort, KY 40601
(502) 564-8519
Kentucky Army National Guard - The Army Guard is composed of citizen-soldiers. Citizens who live and work at home among neighbors and friends, but who are always ready to help in emergencies. Ready to reach out to their community and their country. In return, the Army Guard gives you opportunities to make a bright future even brighter.

We'll pay the fees for civilian medical seminars and professional courses. A retirement program and much more.

Kentucky Medical Insurance Company **Booth 67**
3532 Ephraim McDowell
Louisville, KY 40205
(502) 459-3400
Kentucky Medical Insurance Company, organized by the Kentucky Medical Association, is a professional liability insurance company owned by physicians, run by professionals, with physician input in all areas in which there is need of physician expertise. We welcome the opportunity to discuss the advantages and benefits represented by our program of coverage.

Kentucky Telco Federal Credit Union **Booth 97**
3740 Bardstown Road
Louisville, KY 40218
(502) 459-3000
The only full service financial institution endorsed by the Kentucky Medical Association. A state-wide Federally chartered and Federally insured credit union serving KMA member physicians, their families and staffs, with service centers in Louisville, Lexington and Owensboro. Kentucky Telco offers members above market rates on savings, interest bearing, no fee checking, Visa, Mastercard, and loan rates that are among the best available. Plus, the added bonus of 24-hour, 7-day a week access.

Knoll Pharmaceuticals **Booth 76**
30 N Jefferson Road
Whippany, NJ 07981
(201) 887-8300
Please stop by Booth #76 for information on Isoptin® SR (verapamil HC1) the first once-daily calcium channel blocker approved for treatment of mild to moderate hypertension and Vicodin® (hydrocodone bitartrate [5 mg warning: May be habit forming] and acetaminophen 500 mg).

Lakeview Rehabilitation Hospital **Booth 100**
134 Heartland Drive
Elizabethtown, KY 42701
(502) 769-3100
Lakeview is a 40-bed comprehensive medical rehabilitation hospital located in Elizabethtown, KY, which opened November 23, 1987. We have cared for patients with stroke, spinal cord injury, traumatic head injury, amputations, multiple fractures, total joint replacements, multiple sclerosis, and other physical disabilities. We are operated by Continental Medical Systems, Inc., which is one of the largest rehabilitation corporations in the country and owns Braintree Rehabilitation Hospital in Braintree, Massachusetts; Kentfield Rehabilitation Hospital in Kentfield, California; and Western Neuro Center in Tustin, California.

Lederle Laboratories **Booth 4**
1800 Valley Road
Wayne, NJ 07470
(201) 831-7077
PIPRACIL® is an antibiotic which exerts its bactericidal activity by inhibiting both septum and cell wall synthesis. It is active against a variety of gram-positive and gram-negative aerobic and anaerobic bacteria.
MAXZIDE® TRIAMTERENE/HYDROCHLOROTHIAZIDE — Launched in 1984 by Lederle Laboratories, this product is a combination of two diuretics: hydrochlorothiazide and triamterene. It is used for the treatment of hypertension (high blood pressure) and for the treatment of edema (excess body fluid). Two different diuretic compounds are used in MAXZIDE® to maximize the effectiveness and safety of the product.

Lexington Diagnostic Center **Booth 90**
1725 Harrodsburg Road
Lexington, KY 40504
(606) 278-7441
Services provided at the Lexington Diagnostic Center include: Regular X-ray procedures; Fluoroscopy procedures; Ultrasound procedures; Xerography, CT Scans; and the ultimate in diagnostic imaging procedures, Magnetic Resonance Imaging (MRI). The Lexington Diagnostic Center is a free-standing facility, licensed by the Commonwealth of Kentucky as a diagnostic imaging center to provide diagnostic radiology services to inpatients and outpatients in Central and Eastern Kentucky. Located in the Physician's Mall, 1725 Harrodsburg Road, Lexington, Kentucky 40504, (606) 278-SCAN.

Lippincott Company, J.B. **Booth 33**
903 Deacon Circle
Columbus, OH 43214
(614) 451-2045
J.B. Lippincott will display a variety of

books of interest. Featured will be Kelly: Textbook of Internal Medicine and the three-volume set, Champan: Operative Orthopaedics. Your visit to examine these important new titles will be most welcome.

Marion Laboratories, Inc. **Booth 31**
9300 Ward Parkway
Kansas City, MO 64114
(816) 966-4000
We are pleased to be in attendance again this year, and hope you will stop by our booth and let one of our representatives answer any questions you may have concerning our products. Featured will be CARDIZEM (diltiazem HCl) our exciting calcium channel blocker, and CARAFATE (sucralfate) unique, non-systemic drug for the treatment of ulcers.

McNeil Consumer Products Company **Booth 92**
1603 LBJ Freeway, Suite 760
Dallas, TX 75234
(214) 243-0022
McNeil Consumer Products will feature TYLENOL acetaminophen products, and other McNeil products. MEDIPREN (ibuprofen 200 mg.) Caplets and Tablets will be highlighted, together with Extra-Strength TYLENOL Caplets, and our Children's TYLENOL line, featuring Junior Strength TYLENOL Chewable Tablets. There will be samples and literature of our PEDIACARE line of symptom-specific children's cold products, IMODIUM (loperimide hydrochloride), and antidiarrheal, and DELSYM (dextromethorphan polistirex), a 12-hour cough suppressant. Samples, information aids, etc., will be available.

McNeil Pharmaceuticals **Booth 21**
Spring House, PA 19477
(215) 628-5000

Mead Johnson Nutritionals **Booth 86**
2404 W. Pennsylvania Street
Evansville, IN 47721-0001
(812) 429-7348
We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: Enfamil®, Nutramigen®, ProSobee®.

Mead Johnson Pharmaceuticals **Booth 88**
2404 Pennsylvania Street
Evansville, IN 47721
(812) 429-5000
We cordially invite you to visit our exhibit to meet our representatives who welcome the opportunity to discuss products and services of interest to you. Featured will be: Buspar, Desyrel, Duricef, and Klotrix.

Med Derm, Inc. **Booth 25**
PO Box 5193
Kingsport, TN 37663

Medical Equipment Designs **Booth 84**
509 Quails Run Road
Suite A3
Louisville, KY 40207
(502) 893-0620
Spirometry and/or Holter Monitoring for the physicians' office. The MultiSpiro Spirometer has computer interpretation, incentive displays to coax patient cooperation and an easy cleaning flow element to avoid contamination. Meets all social security disability, NIOSH and OSHA test standards. Typically, two tests per month pay for your own in-office spirometer. Designed for upgradeability to a dual channel, real time or full disclosure, ambulatory ECG monitoring recorder which detects and records arrythmias.

Medical Management Resources **Booth 15**
10200 Linn Station Road
Louisville, KY 40223
(502) 423-0793
Medical Management Resources will present its "Genius" product line. The Genius products and services are designed to fill the needs of the busy medical office regardless if the office is automated or not.
The Genius products and service include full financial functions, electronic claim submission, Medicare and Blue Cross and Blue Shield benefit eligibility, Medicare and Blue Cross and Blue Shield claim status inquiry.

Medical Protective Company, The **Booth 73**
5814 Reed Road
Fort Wayne, IN 46815
(219) 485-9622
The Medical Protective Company provides unexcelled protection in any claim for damages based on professional services rendered or which should have been rendered. The Company's experience from the successful handling of over 150,000 claims during 89 years of Professional Pro-

tection Exclusively is unparalleled in the professional liability field.

Mednet, Inc. **Booth 54**
2720 SE Loop 820
Fort Worth, TX 76140
(817) 293-2000
Consulting, data processing, computer services, full service billing and practice management service for clinics and physicians.

Merck, Sharp and Dohme **Booth 93**
West Point
PA 19486
(215) 661-5349

Miles Inc., Diagnostics Division **Booth 62**
PO Box 70
Elkhart, IN 46515
(219) 262-7846
We will be displaying the Clinitek 10, Seralyzer III and the Glucometer II and Glucometer M.

Miles Pharmaceuticals **Booth 81**
400 Morgan Lane
West Haven, CT 06516
(203) 934-9221

Norton Psychiatric Hospital **Booth 91**
PO Box 35070
Louisville, KY 40232
(502) 562-8880

Olympus Corporation **Booth 7**
1805 Crossgate Lane
Louisville, KY 40222
(502) 426-9370
Please stop at the booth and say, "Hi!" We will be showing the new Endotherapy Equipment Systems. The Endoscopic Video Information Systems/Videoimage Endoscope System, a new flexible Sigmoidoscope, will be at the booth. Olympus - the full-line Endoscopy Company!

Ortho Pharmaceutical Corp **Booth 9**
Route 202
Raritan, NJ 08869
(201) 218-6943
Ortho Pharmaceutical Corporation will present the most complete line of medically accepted products for the control of conception. The ORTHO-NOVUM* brands, which are the country's most frequently prescribed oral contraceptives, will be on display. The first tri-phasic oral contraceptive, ORTHO-NOVUM 7/7/7, will be featured. Also featured will be a wide variety of educational aids and gynecological therapeutic products.
*Trademark

Our Lady of Peace Hospital **Booth 64**
2020 Newburg Road
Louisville, KY 40232
(502) 451-3330
One of the largest private psychiatric facilities in the nation, Our Lady of Peace provides quality treatment of children, adolescents and adults with psychiatric and chemical dependency problems. Our display will feature information about the hospital, as well as stress indicators and other informative items.

PCI Diagnostic Systems, Inc. **Booth 27**
93 West Franklin Street
Dayton, OH 45459
(513) 435-2273
Our booth will feature spirometry products, vascular recorder Doppler, as well as a complete line of monitoring products. The monitoring products include ambulatory blood pressure monitors used to measure high blood pressure on a 24-hour basis. Holter monitors used for 24-hour ECG measurements. Also, transtelephonic monitoring featuring the new king of hearts by Instromedix will be displayed.

PIE Mutual Insurance Company **Booth 26**
2240 Meidinger Tower (Galleria)
Louisville, KY 40202
(502) 339-7431 (KY WATS 1-800-228-7431)
PIE Mutual Insurance Company of Cleveland, Ohio now offers Kentucky physicians the advantages of an insurance program that has made it the leading professional liability carrier in Ohio. Direct physician involvement in the Company's operations, through regional managing boards, allows PIE to offer an innovative program of insurance that provides stable rates while rewarding loss-free physicians with scheduled premium reductions beginning in the second year of coverage.

Parke-Davis **Booth 28**
201 Tabor Road
Morris Plains, NJ 07950
(201) 540-2000

We invite you to visit the Parke-Davis booth where our sales representatives welcome the opportunity to discuss and assist you regarding Parke-Davis products. We hope you will join us.

Pfizer Laboratories **Booth 65**
New York, NY 10017
(502) 241-1082

Princeton Pharmaceutical Products **Booth 101**
PO Box 4500
Princeton, NJ 08543-4500
(609) 243-6203
Princeton Pharmaceutical Products has long been a leader in the development of therapeutic and diagnostic products for the prevention, detection, and treatment of disease. You are cordially invited to meet representatives who will be available to discuss the full line of Princeton Pharmaceutical Products.

Quality X-Ray Services, Inc. **Booth 18**
3965 Industrial Boulevard
Indianapolis, IN 46254
(317) 291-0391
A variety of medical x-ray equipment specifications and literature will be provided. Equipment lines featured include Bennett X-Ray, and a new American manufactured line of hospital grade radiographic equipment - AMERISYS. Accessories featured include: automatic film processors, illuminators, lead aprons, etc. X-ray supplies and service information will also provide information on physical therapy equipment and supplies through its Physical Therapy Division. Technical specialists will be on hand to answer questions.

Ransdell Surgical, Inc. **Booth 50**
752 Barret Avenue
Louisville, KY 40204
(502) 584-6311
Medical products and services - the need exists. And it is our endeavor to fulfill these needs in the most efficient and cost-effective manner. We distribute popular brands you know and trust. Our innovative warehousing techniques, inventory control, dependable delivery, and financial stability are indicative of our high standards, but we consider the skill and dedication of our people our greatest asset. Ransdell Surgical . . . dedicated to the support of the Kentucky and Southern Indiana Healthcare Provider.

Rivendell of Kentucky **Booth 99**
200 Rivendell Drive
Bowling Green, KY 42101
(502) 843-1199
Psychiatric hospital for children and adolescents.

Robins Company, A.H. **Booth 8**
1407 Cummings Drive
Richmond, VA 23220
(804) 257-2563
You are cordially invited to visit the A.H. Robins exhibit and meet our representatives who will welcome the opportunity to discuss our products: Tenex and Micro-K.

Roche Biomedical Laboratories, Inc. **Booth 14**
6370 Wilcox Road
Dublin, OH 43017
(614) 889-1061
We are a full-service Reference Medical Laboratory servicing physicians, hospitals and clinics throughout the United States.

Roerig, J. B. **Booth 11**
4360 NE Expressway
Doraville, GA 30340
(404) 448-6666
Unasyn, (Ampicillen-Sulbactum), Glucotrol and Cefobid will be featured.

Rorer Pharmaceuticals **Booth 48**
500 Virginia Drive
Fort Washington, PA 19034
(215) 628-6000
We are pleased to be part of this medical meeting and welcome your visiting our exhibit. Representatives will be available to discuss pharmaceuticals manufactured by Rorer Pharmaceuticals, including Lozol®, Calcimar®, Nitrolingual® Spray, Slo-bid™, and Azmacort™.

Sandoz **Booth 52**
59 Route 10
East Hanover, NJ 07936

Schering Corp **Booth 61**
Kenilworth
NJ 07033

Searle, G. D. & Company **Booth 3**
PO Box 5110
Chicago, IL 60680
(312) 470-6712
You are cordially invited to visit the Searle booth where our representatives will be happy to answer any questions regarding Searle products. Featured will be information on CALAN® SR, NITRODISC®, DEMULEM 1/35™, and other products of interest.

Skycare, Inc. **Booth 75**
217 East Chestnut Street
Louisville, KY 40202
(502) 587-4777
Skycare, Inc. is a hospital-based aeromedical service located at Jewish Hospital in Louisville, Kentucky. Skycare, Inc. serves Kentucky, Southern Indiana, and areas of six bordering states. Skycare, Inc. utilizes an Agusta 109 MKII twin engine helicopter within a 175 mile radius of Louisville. A number of fixed wing aircraft are available for transports up to 1000 miles from Louisville. Fixed wing transports of farther distances are made upon request. The Skycare, Inc. aircraft are staffed with a pilot, nurse and paramedic.

Smith, Kline and French **Booth 68**
PO Box 7929 (E22)
Philadelphia, PA 19101
(215) 751-3668

Southern Medical Association **Booth 10**
35 Lakeshore Drive
Birmingham, AL 35209
(205) 945-1840
Southern Medical Association will have information available on the advantages of membership, such as Dial Access, Video Access, Special Seminars and Section Meetings, the Annual Scientific Assembly, the SOUTHERN MEDICAL JOURNAL, and the SMA Auxiliary. Also, material will be available on other benefits to members: the IRA, Retirement and Insurance Programs, Endowment Fund, Loans and Scholarships, Hyatt Gold Passport, Gold MasterCard, SMA Travel Services and the Physicians' Purchasing Program.

Squibb, E. R. & Sons **Booth 56**
PO Box 4500
Princeton, NJ 08543-4500
(609) 243-6203
E.R. Squibb & Sons has long been a leader in the development of the therapeutic and diagnostic products for the prevention, detection, and treatment of disease. You are cordially invited to meet representatives who will be available to discuss the full line of E.R. Squibb & Sons' products.

Stuart Pharmaceuticals **Booth 39**
503 Scioto Drive
Louisville, KY 40223
(502) 425-6540

Syncor Parenteral Pharmacy Services **Booth 104**
20001 Prairie Street
Chatsworth, CA 91311
(818) 886-7400

UpJohn Company **Booth 83**
4910 Para Drive
Cincinnati, OH 45237
(513) 242-4574
XANAX®, MICRONASE®, CLEOCIN®, HALCION®, PROVERA®, MOTRIN®, and HealthScope™.

Upjohn Healthcare Services **Booth 72**
4000 DuPont Circle
Louisville, KY 40207
(502) 895-4213

U.S. Air Force Medical Recruiting **Booth 71**
841 Corporate Drive
Lexington, KY 40503
(606) 223-7038

U.S. Army Health Professional Support Agency **Booth 29**
5111 Leesburg Pike, Suite 638
Falls Church, VA 22041-3258
(703) 756-8124
Physician Placement Service for the US Army Medical Department, both active duty and reserve. Information will be available about financial assistance programs for medical students, Graduate Medical Education opportunities, and the large number of challenging positions in both the Active Army and the US Army Reserve.

Westwood Pharmaceuticals **Booth 70**
100 Forest Avenue
Buffalo, NY 14213
(716) 887-3400

Westwood®, Science Devoted to Better Skin Care, welcomes you to the 1988 Annual Meeting of the Kentucky Medical Association. Please visit our exhibit where we will be happy to discuss our fine line of dermatological products.

Whitehall Laboratories **Booth 44**
685 Third Avenue
New York, NY 10017
(212) 878-5073
Whitehall Laboratories, a Division of American Home Products is a leader in its field and is recognized for its high-quality products. Among them is Anacin, Anacin-3, Preparation-H, and Dristan.

Ibuprofen, one of the most widely used agents in modern medicine, has attained over-the-counter (OTC) status in an OTC strength as Advil 200 mg. tablets, a new product of Whitehall Laboratories.

Winthrop Pharmaceuticals **Booth 59**
90 Park Avenue
New York, NY 10016
(212) 907-2000 Home Office Number
(502) 425-1466 Local Number

Wyeth-Ayerst Laboratories **Booths 5-6**
PO Box 8299
Philadelphia, PA 19101
(215) 971-5307
Please visit the Wyeth-Ayerst Laboratories' exhibit and our representatives will be happy to discuss Ativan®, Bicillin®, Deponit®, Nordette®, Nursoy®, Orudis®, Phenergan Syrup®, Resol®, Sectral®, SMA®, Triphasil®, Wytensin®, Inderal®, Premarin®, and other products and services of interest to you.

Roche-Diagnostic Systems **Booth 22**
Montclaire, NJ 07042
(606) 341-3820
Chemistry instrumentation and reagents.

1988 Contributors

Bristol-Myers Oncology Division
U.S. Pharmaceutical and Nutritional Group
Evansville, IN 47721

Merrell Dow Pharmaceuticals Inc.
Subsidiary of The Dow Chemical Company
Cincinnati, OH 45242-9553

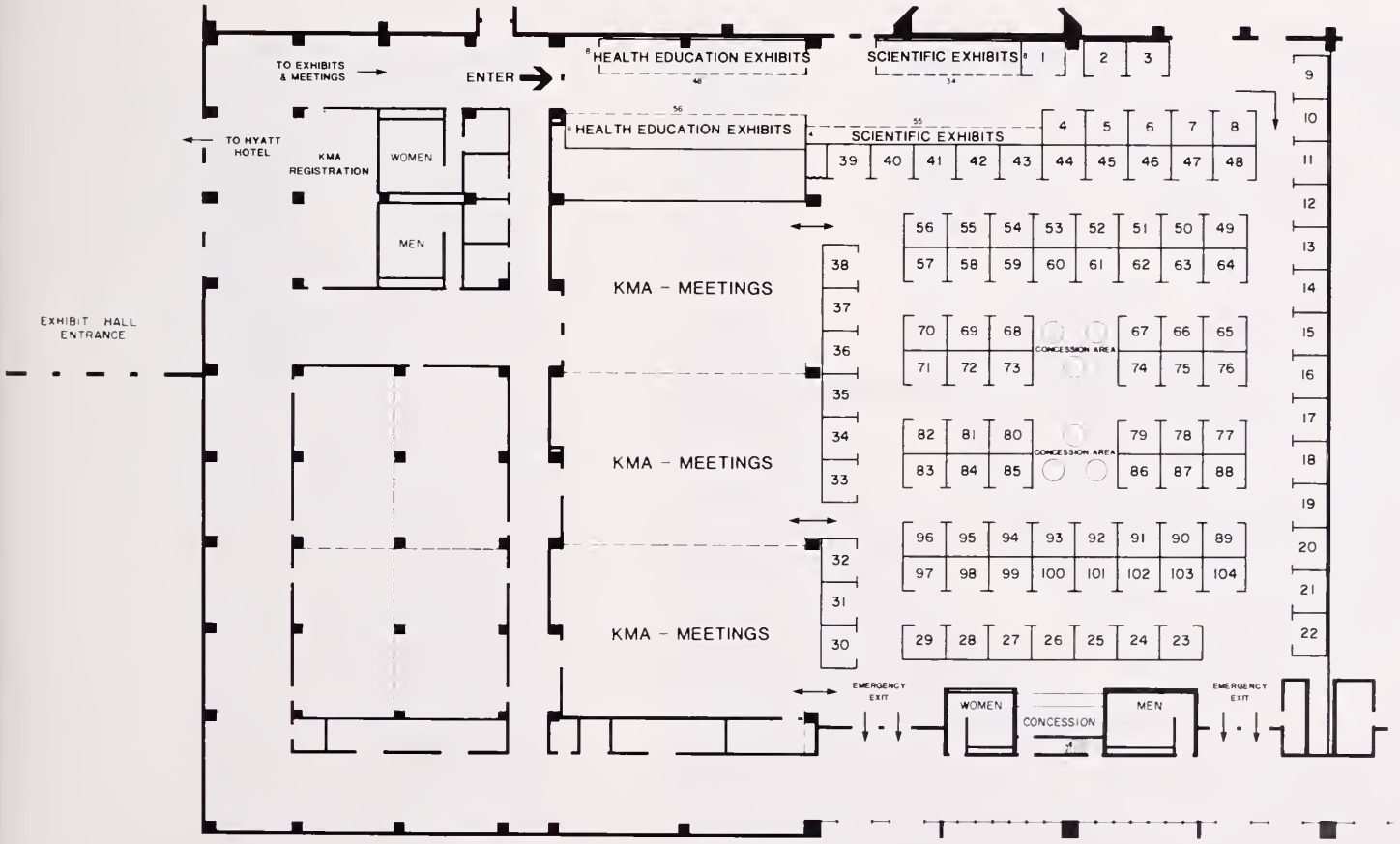
Technical Exhibits

The Technical Exhibits at the 1988 KMA Annual Meeting will feature the latest developments in medical techniques and information. Located in the Hyatt Regency, Lexington/Lexington Center, the exhibits will condense a volume of information and ideas in such a manner that a vast amount of knowledge can be secured in a short period of time.

Prepared carefully and skillfully to appeal to you, the physician, the exhibits are especially geared to your special interests as a practitioner. Medical representatives and other exhibitors will be on hand to discuss personally their products and services with you. Both you and your patients should benefit from the information that can be gained from a visit to the Technical Exhibits.

Thirty-minute intermissions have been planned during each general and specialty group session so that every physician may take advantage of this excellent opportunity provided by the exhibits.

LEXINGTON CENTER
LEXINGTON, KENTUCKY



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MSgt Todd H. Beasley at
(502) 364-9424 (Call Collect

Impaired Physicians Committee

is for the alcoholic/ chemically dependent physician.

For more information call

502-459-9790

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Give yourself a hand against breast cancer



Breast self-examination is easy, takes only a few minutes and can be performed in the privacy of your own home. It's an important way you can detect early and highly curable breast cancer.

Take control of your body and your life.

Make breast self-examination a part of your monthly routine. And see your doctor regularly for clinical exams and advice on mammography.

For a free pamphlet about breast self-examination, call your local American Cancer Society.

We're here to help.

AMERICAN CANCER SOCIETY®

Make Your Reservations Now

It is important that you begin to make your room reservations as soon as possible for the KMA Annual Meeting, September 26-29. The Hyatt Regency Lexington will be the Headquarters Hotel. However, there are several other accommodations within easy reach of the Hyatt Regency Lexington/Lexington Center. In making your reservations, remember the first House of Delegates meeting will be Monday, September 26.

New this year . . .

One more reason to join the AMA

Special benefit packages available with 1988 membership

A diverse membership has diverse needs, and the AMA is committed to addressing those needs. This year we're introducing something new when you join the AMA or renew your membership. In your AMA Membership Kit you'll have the opportunity to sign up for one of three *benefit packages* of publications, conferences, participatory panels, focused issue updates, etc., on topics related to the area you designate. Each package is tailored to address your particular interests:

- *Medical and scientific information and education* designed to enhance your practice, profession, and the public health.
- *Representation concentrated specifically on economic concerns,* such as professional liability and third party reimbursement.
- *Representation on a broad range of issues,* including not only economic concerns, but also quality of care, ethical issues, public health, and scientific issues.

To receive your full range of benefits, select one and only one of these free packages by filling out the business reply card in your AMA Membership Kit.

Please look for the card in your AMA Membership Kit and return it promptly. Your new benefit package is one more way the AMA supports you as a physician.

James H. Sammons, MD
Executive Vice President

American Medical Association
535 North Dearborn Street; Chicago, Illinois 60610



Most patients need only one.

K-DUR™ 20 Microburst Release System™
(potassium chloride) 20mEq Sustained Release Tablets

A daily prophylactic dose in a single tablet.

Please see next page for brief summary of prescribing information.

Key Pharmaceuticals, Inc.
Kenilworth, NJ 07033
World leader in drug delivery systems.

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K-DUR™ Microburst Release System®
(potassium chloride) Sustained Release Tablets

INDICATIONS AND USAGE: BECAUSE OF REPORTS OF INTESTINAL AND GASTRIC ULCERATION AND BLEEDING WITH SLOW-RELEASE POTASSIUM CHLORIDE PREPARATIONS, THESE DRUGS SHOULD BE RESERVED FOR THOSE PATIENTS WHO CANNOT TOLERATE OR REFUSE TO TAKE LIQUID OR EFFERVESCENT POTASSIUM PREPARATIONS OR FOR PATIENTS IN WHOM THERE IS A PROBLEM OF COMPLIANCE WITH THESE PREPARATIONS.

1. For therapeutic use in patients with hypokalemia with or without metabolic alkalosis, in digitalis intoxication and in patients with hypokalemic familial periodic paralysis.

2. For the prevention of potassium depletion when the dietary intake is inadequate in the following conditions: Patients receiving digitalis and diuretics for congestive heart failure, hepatic cirrhosis with ascites, states of aldosterone excess with normal renal function, potassium-losing nephropathy, and with certain diarrheal states.

3. The use of potassium salts in patients receiving diuretics for uncomplicated essential hypertension is often unnecessary when such patients have a normal dietary pattern. Serum potassium should be checked periodically, however, and if hypokalemia occurs, dietary supplementation with potassium-containing foods may be adequate to control milder cases. In more severe cases supplementation with potassium salts may be indicated.

CONTRAINDICATIONS: Potassium supplements are contraindicated in patients with hyperkalemia since a further increase in serum potassium concentration in such patients can produce cardiac arrest. Hyperkalemia may complicate any of the following conditions: Chronic renal failure, systemic acidosis such as diabetic acidosis, acute dehydration, extensive tissue breakdown as in severe burns, adrenal insufficiency, or the administration of a potassium-sparing diuretic (e.g., spironolactone, triamterene).

Wax-matrix potassium chloride preparations have produced esophageal ulceration in certain cardiac patients with esophageal compression due to enlarged left atrium.

All solid dosage forms of potassium chloride supplements are contraindicated in any patient in whom there is cause for arrest or delay in tablet passage through the gastrointestinal tract. In these instances, potassium supplementation should be with a liquid preparation.

WARNINGS: Hyperkalemia—In patients with impaired mechanisms for excreting potassium, the administration of potassium salts can produce hyperkalemia and cardiac arrest. This occurs most commonly in patients given potassium by the intravenous route but may also occur in patients given potassium orally. Potentially fatal hyperkalemia can develop rapidly and be asymptomatic. The use of potassium salts in patients with chronic renal disease, or any other condition which impairs potassium excretion, requires particularly careful monitoring of the serum potassium concentration and appropriate dosage adjustment.

Interaction with Potassium Sparing Diuretics—Hypokalemia should not be treated by the concomitant administration of potassium salts and a potassium-sparing diuretic (e.g., spironolactone or triamterene) since the simultaneous administration of these agents can produce severe hyperkalemia.

Gastrointestinal Lesions—Potassium chloride tablets have produced stenotic and/or ulcerative lesions of the small bowel and deaths. These lesions are caused by a high localized concentration of potassium ion in the region of a rapidly dissolving tablet, which injures the bowel wall and thereby produces obstruction, hemorrhage or perforation.

K-DUR tablets contain micro-crystalloids which disperse upon disintegration of the tablet. These micro-crystalloids are formulated to provide a controlled release of potassium chloride. The dispersibility of the micro-crystalloids and the controlled release of ions from them are intended to minimize the possibility of a high local concentration near the gastrointestinal mucosa and the ability of the KCl to cause stenosis or ulceration. Other means of accomplishing this (e.g., incorporation of potassium chloride into a wax matrix) have reduced the frequency of such lesions to less than one per 100,000 patient years (compared to 40–50 per 100,000 patient years with enteric-coated potassium chloride) but have not eliminated them. The frequency of GI lesions with K-DUR tablets is, at present, unknown. K-DUR tablets should be discontinued immediately and the possibility of bowel obstruction or perforation considered if severe vomiting, abdominal pain, distention, or gastrointestinal bleeding occurs.

Metabolic Acidosis—Hypokalemia in patients with metabolic acidosis should be treated with an alkalinizing potassium salt such as potassium bicarbonate, potassium citrate, potassium acetate, or potassium gluconate.

PRECAUTIONS: The diagnosis of potassium depletion is ordinarily made by demonstrating hypokalemia in a patient with a clinical history suggesting some cause for potassium depletion. In interpreting the serum potassium level, the physician should bear in mind that acute alkalosis per se can produce hypokalemia in the absence of a deficit in total body potassium while acute acidosis per se can increase the serum potassium concentration into the normal range even in the presence of a reduced total body potassium. The treatment of potassium depletion, particularly in the presence of cardiac disease, renal disease, or acidosis requires careful attention to acid-base balance and appropriate monitoring of serum electrolytes, the electrocardiogram, and the clinical status of the patient.

Laboratory Tests: Regular serum potassium determinations are recommended. In addition, during the treatment of potassium depletion, careful attention should be paid to acid-base balance, other serum electrolyte levels, the electrocardiogram, and the clinical status of the patient, particularly in the presence of cardiac disease, renal disease, or acidosis.

Drug Interactions: Potassium-sparing diuretics; see **WARNINGS.**

Carcinogenesis, Mutagenesis, Impairment of Fertility: Long-term carcinogenicity studies in animals have not been performed.

Pregnancy Category C: Animal reproduction studies have not been conducted with K-DUR. It is also not known whether K-DUR can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. K-DUR should be given to a pregnant woman only if clearly needed.

Nursing Mothers: The normal potassium ion content of human milk is about 13 mEq per liter. Since oral potassium becomes part of the body potassium pool, so long as body potassium is not excessive, the contribution of potassium chloride supplementation should have little or no effect on the level in human milk.

Pediatric Use: Safety and effectiveness in children have not been established.

ADVERSE REACTIONS: One of the most severe adverse effects is hyperkalemia (see **CONTRAINDICATIONS, WARNINGS,** and **OVERDOSAGE).** There have also been reports of upper and lower gastrointestinal conditions including obstruction, bleeding, ulceration, and perforation (see **CONTRAINDICATIONS** and **WARNINGS);** other factors known to be associated with such conditions were present in many of these patients.

The most common adverse reactions to oral potassium salts are nausea, vomiting, abdominal discomfort, and diarrhea. These symptoms are due to irritation of the gastrointestinal tract and are best managed by taking the dose with meals or reducing the dose.

Skin rash has been reported rarely.

OVERDOSAGE: The administration of oral potassium salts to persons with normal excretory mechanisms for potassium rarely causes serious hyperkalemia. However, if excretory mechanisms are impaired or if potassium is administered too rapidly intravenously, potentially fatal hyperkalemia can result (see **CONTRAINDICATIONS** and **WARNINGS**). It is important to recognize that hyperkalemia is usually asymptomatic and may be manifested only by an increased serum potassium concentration and characteristic electrocardiographic changes (peaking of T-waves, loss of P-waves, depression of S-T segment, and prolongation of the QT-interval). Late manifestations include muscle-paralysis and cardiovascular collapse from cardiac arrest.

Treatment measures for hyperkalemia include the following:

1. Elimination of foods and medications containing potassium and of potassium-sparing diuretics.
2. Intravenous administration of 300 to 500 ml/hr of 10% dextrose solution containing 10–20 units of insulin per 1,000 ml.
3. Correction of acidosis, if present, with intravenous sodium bicarbonate.
4. Use of exchange resins, hemodialysis, or peritoneal dialysis.

In treating hyperkalemia, it should be recalled that in patients who have been stabilized on digitalis, too rapid a lowering of the serum potassium concentration can produce digitalis toxicity.

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The University of Louisville School of Medicine, Department of Pediatrics, John I. Perlstein Lectureship,
Health Sciences Center Auditorium, Abraham Flexner Way, Louisville, KY. Contact: Linda S. Ecker, Academic Coordinator, Department of Pediatrics, School of Medicine, University of Louisville, Louisville, KY 40292, (502) 562-8826.

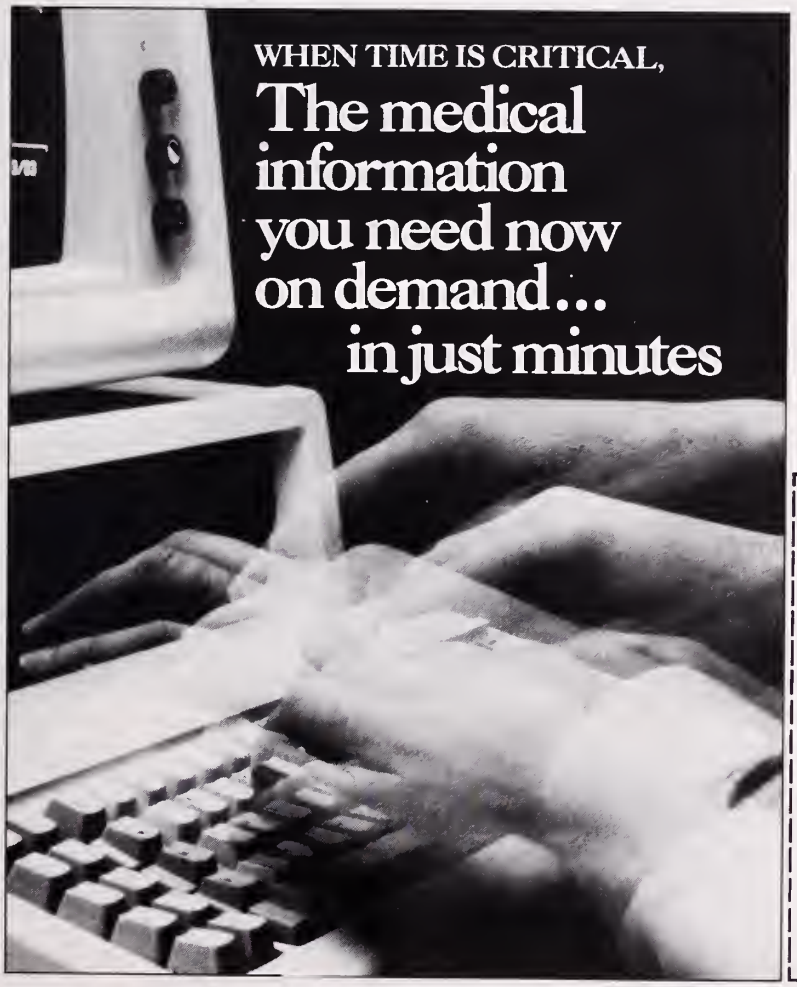
September 3-5
Fourth Annual Multispecialty Oculoplastic Surgery Symposium,
Lexington Marriott Resort, Lexington, KY. Contact: Jennifer DePrima Richard, Ophthalmology Center, Humana Hospital-Lexington, 150 N Eagle Creek Dr, Lexington, KY 40509, (606) 268-3754.

October 12-13
Care of the Seriously Ill Child —
The 16th Annual Fall Pediatric Surgery/ Pediatrics Symposium concerning "Acute Pediatric Emergencies," Lincoln Hotel and University Conference Center, Indianapolis, IN. Sponsored by the Indiana University School of Medicine. Contact: Jay L. Grosfeld, MD, (Symposium Director) Surgeon-in-Chief, Riley Hospital, 702 Barnhill Dr, Indianapolis, IN 46223, (317) 274-8353.

October 27
Health Fraud Conference,
Campbell House, Lexington, KY. Sponsors include the University of Kentucky Cooperative Extension Service, Kentucky Dietetic Association, University of Kentucky School of Nursing and the Attorney General's Health Fraud Task Force. Contact: Darlene Forester, PhD, RD, University of Kentucky, 120 Erikson Hall, Lexington, KY 40506, (606) 257-1812.

November 10-11
22nd Annual Newborn Symposium,
Kosair Children's Hospital Auditorium, 200 E. Chestnut St., Louisville, KY. Larry N. Cook, MD, Professor and Associate Chairman, Department of Pediatrics, will be Program Chairman. Contact: Linda S. Ecker, Academic Coordinator, Department of Pediatrics, School of Medicine, University of Louisville, Louisville, KY 40292, (502) 562-8826.

December 7-9
American Cancer Society, National Conference on Advances in Cancer Management,
Hyatt Regency Hotel, Los Angeles, California. Contact: American Cancer Society, National Conference on Advances in Cancer Management, 3340 Peachtree Rd, NE, Atlanta, GA 30026. (212) 599-3600.



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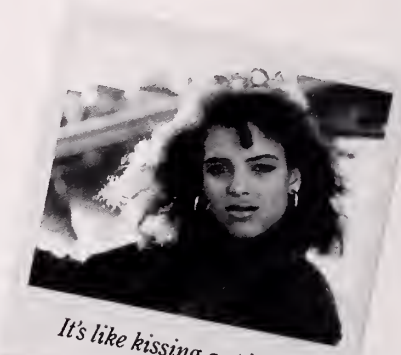
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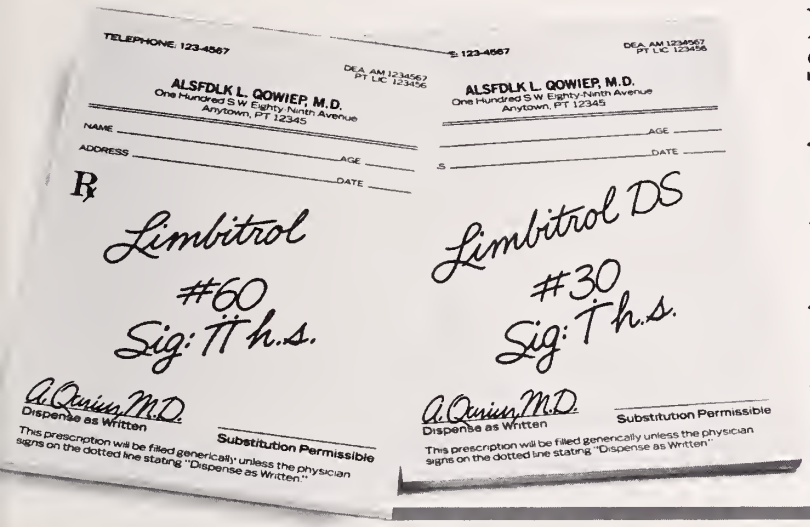
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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

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Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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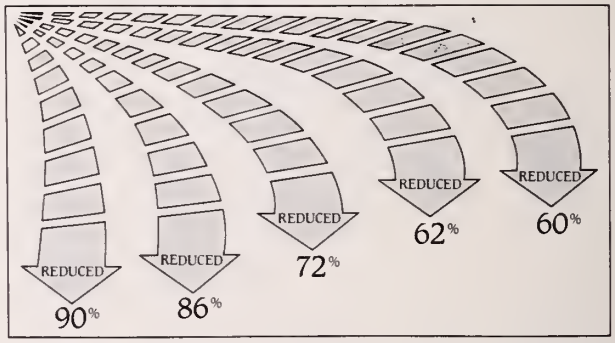
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Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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*Patients often presented with more than one somatic symptom.

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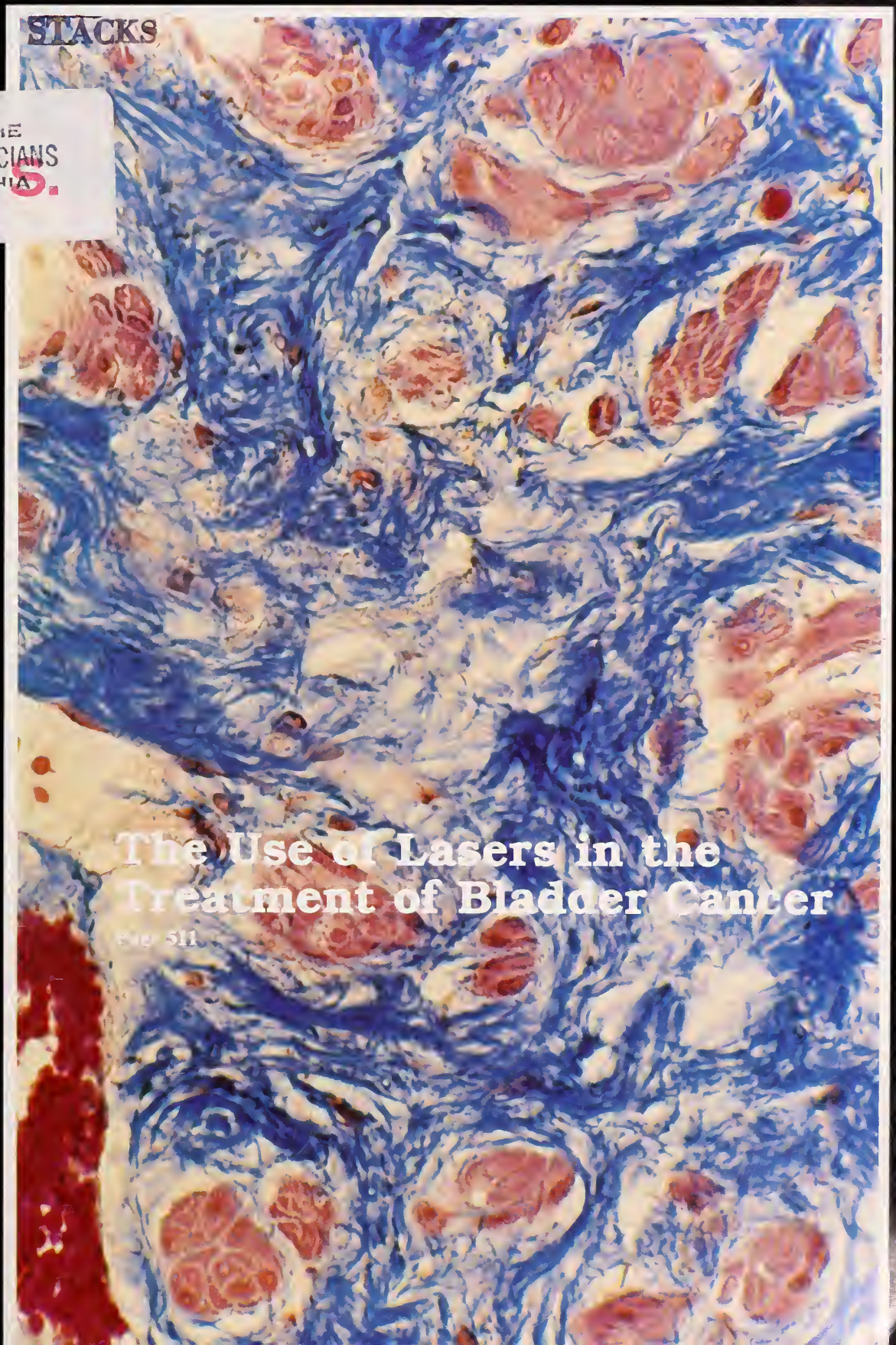
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The Use of Lasers in the Treatment of Bladder Cancer

Page 511

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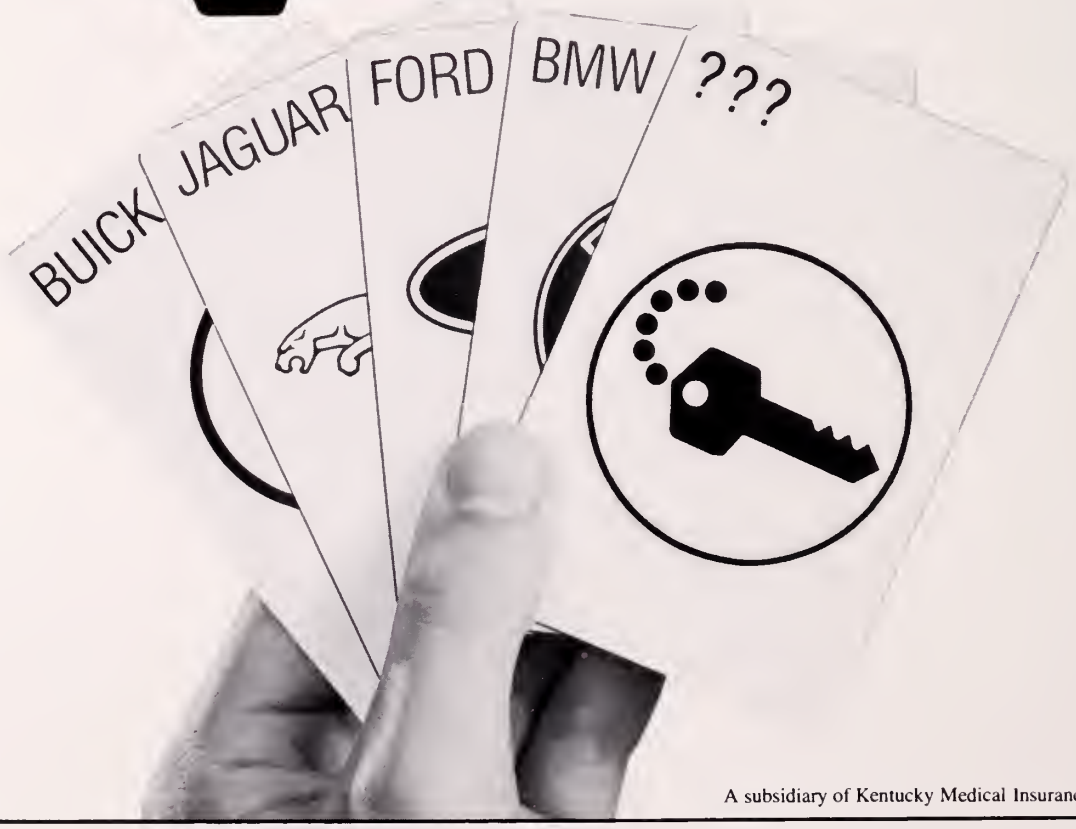
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The cover photograph demonstrates the fibrous tissue (blue) which has replaced bladder muscle (pink) following photodynamic therapy for bladder cancer (see text). The photograph is courtesy of Douglas Ackerman, MD, Department of Pathology, University of Louisville, Louisville, KY.

SCIENTIFIC

Pott's Disease in Kentucky: Diagnosis and Treatment
Thomas M. Roy, MD; Chuck Giles, MD; Jose Mendieta, MD; Miguel A. Ossorio, MD **499**

Speech and Language Screening of Children from Birth to 6 years of Age
Karen F. Steckol, PhD **503**

The Use of Lasers in the Treatment of Bladder Cancer (Grand Rounds)
James I. Harty, MD **511**

EDITORIAL

Interference **521**

ASSOCIATION

Highlights of Emergency Medical Care Seminar **526**
Physician's Recognition Award Recipients **528**
Nelson B. Rue, MD, Nominated for KMA President-Elect **529**
Rural Kentucky Medical Scholarship Fund, Inc. **530**
In Memoriam **532**

REGULAR FEATURES

President's Page **495**
Auxiliary **523**
CME **536**
Classified **535**
Information for Authors **520**

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September Buyer's Guide For Journal of KMA

Charleston Area Medical Center....497, 519
Classified 535
Elcomp Systems, Inc. 496
HFH, Inc. 524
Humana Hospitals 525
Insurance Corporation of America 516-517
KMA Insurance Agency, Inc. 494
KMIC 498
KMIC Leasing Company 490
Eli Lilly & Company 508
Medical Administration Publications 510
Medical Protective Company 509
Naval Reserve Force 531
Palisades Pharmaceuticals, Inc. 520
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PRESIDENT'S PAGE



'Tis sad, the setting of the sun; not for things accomplished but for things we haven't done. It has been a fine year, but there are many challenges ahead.

As you have heard me say many times, this Legislative Session was the finest I have seen in my KMA history. There was more enthusiasm and more colleagues and spouses involved than ever before. But, we have only just begun. We must use our success as only a building block, until we get meaningful tort reform through the legislature. We must be successful in passing a constitutional amendment on non-economic damages and some kind of relief for our colleagues involved in delivering and caring for our children.

Our KMA, AMA, and KEMPAC memberships are all up this year, but we can not be satisfied until all three are 100%. If we are to leave a legacy to our children and grandchildren in medicine, we must be *unified* and *all* involved in accomplishing our goals. Ours is the greatest profession on earth, and it behooves each of us to give of our time and effort to maintain what our forefathers in medicine gave to us.

We will be faced in the coming years with many issues, including RB-RVS, voluntary medicare assignment, and indigent care, including continuing our Kentucky Physician Care Program. I know that all of us, working together for the good of our patients, our profession, and the citizens of our Commonwealth, *will* find the correct and proper course of action to follow.

In closing, I must thank all of you for the support you have given me this year. I have received many letters, phone calls, smiles, etc, and I thank all of you. *You* did a great job this past year. I also want to thank our officers, staff, and Board of Trustees. I would be remiss if I didn't single out two colleagues for the outstanding job they have done for me and all of you: Wally Montgomery, State Legislative Chairman, and Bill Monnig, Chairman of the Board of Trustees. Thank you!

The presidency is being turned over to very capable hands — Bob DeWeese. I ask you to give him the support you have given me, and I know you will. Darkness has come. Good night.

Donald C. Barton, MD
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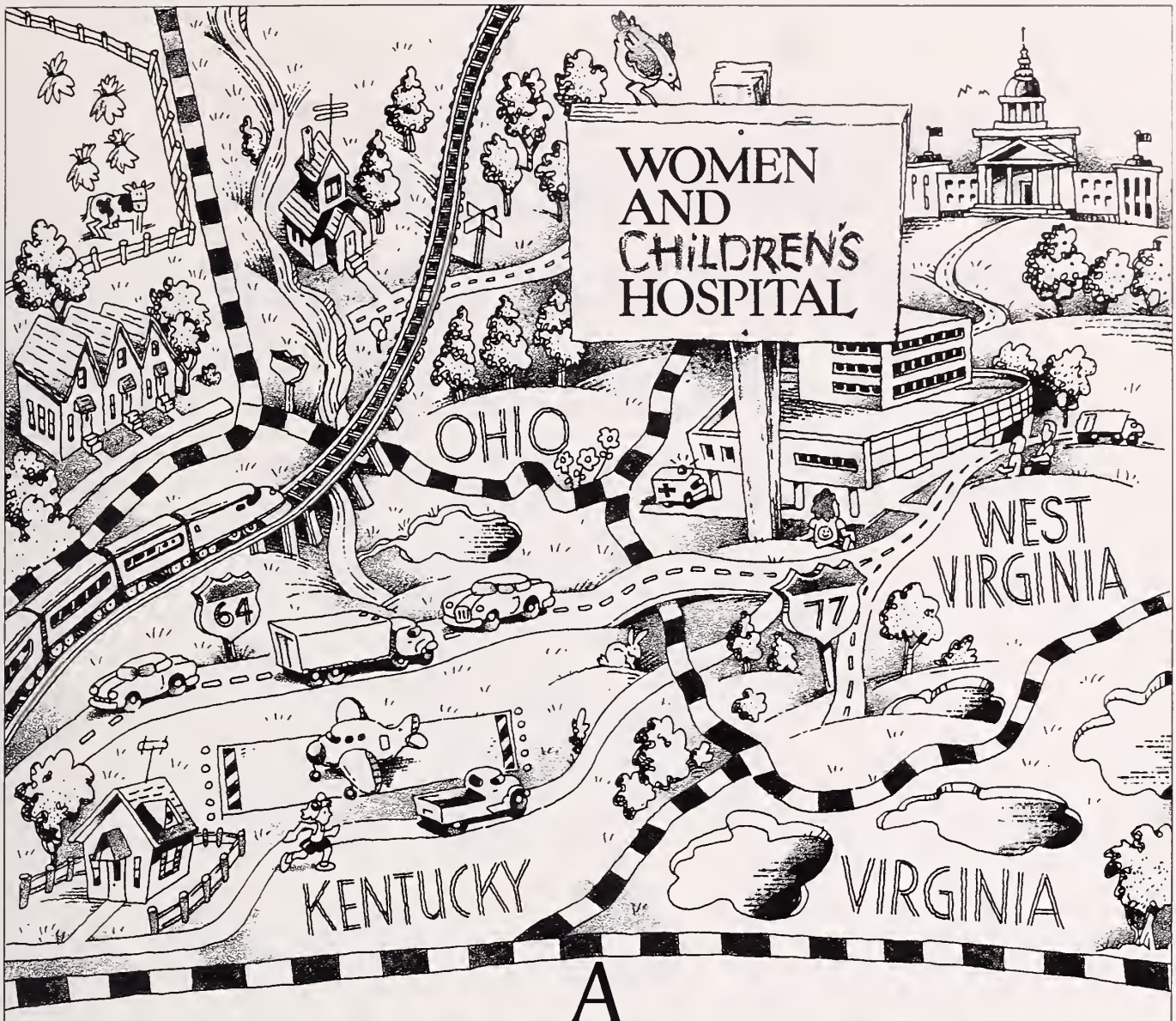
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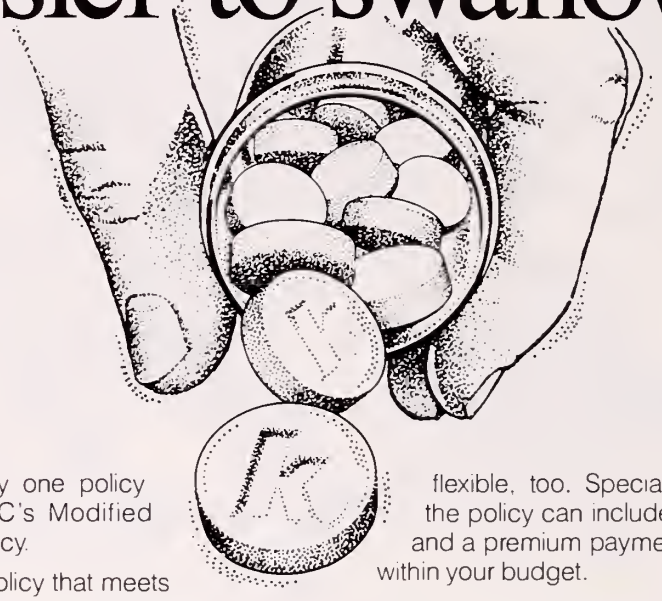
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Pott's Disease in Kentucky: Diagnosis and Treatment

From the Division of Respiratory and Environmental Medicine, University of Louisville School of Medicine, Louisville, Kentucky 40292.

Thomas M. Roy, MD
Chuck Giles, MD
Jose Mendieta, MD
Miguel A. Ossorio, MD

Although there has been a decrease in the number of cases of active tuberculosis nationally, the incidence of extrapulmonary tuberculosis has remained unchanged. The development of excellent antituberculous chemotherapy has simplified our approach to treatment and is now recommended for initial treatment of most types of TB. We recently cared for a patient with tuberculous spondylitis and discovered that there still exists reasonable controversy regarding the most reasonable approach to this form of extrapulmonary TB. We were surprised to find other cases of tuberculosis of the spine that had been diagnosed in Jefferson County, KY in the last 18 months. This review addresses the diagnostic methods and treatment guidelines for the practitioner who may be faced with a patient with Pott's Disease.

Introduction

The national decrease in active cases of tuberculosis (TB) has shifted the care for patients with this infection from the TB specialist to the primary care practitioner. Concurrent with this decline in the number of cases of active pulmonary TB has been the tendency for TB to manifest itself in older age groups with concurrent illnesses that can mimic or disguise its extrapulmonary manifestations.

Few physicians can claim to have widespread experience with extrapulmonary tuberculosis, especially spinal tuberculosis. As a result, we must often look to the experiences of the third world countries, where tuberculous spondylitis is more widespread, for our treatment guidelines. We must acknowledge, however, that the population demographics are different and the methods of treatment available, specifically the antituberculous regimens, are quite variable. In the United States, controversy still exists regarding the choice of antituberculous agents, the duration of treatment, and the need for and timing of surgical intervention.

This review concerns spinal tuberculosis and addresses the clinical presentations, diagnostic methods, and treatment guidelines based upon studies reported in the English language, with the intention of providing useful information to the practitioner who is faced with a case of tuberculous spondylitis.

Case Report

W.M. is a sixty-nine-year-old male admitted to the Louisville Veteran's Administration Medical Center with complaints of progressive weakness, anorexia, back pain, and dyspnea. He had been diagnosed one year earlier as having chronic obstructive pulmonary disease which required treatment with corticosteroids and home oxygen. He had lost 35 pounds in the six months prior to admission. Two months before admission, a chest x-ray was performed and showed a compression fracture at T-11. The patient denied any known infection or exposure to tuberculosis and was unaware of any prior PPD skin tests. Occupational history was unremarkable, as was the family history. The patient had smoked two packs of cigarettes per day for 50 years. Admission examination confirmed normal vital signs, except for an irregularly irregular pulse. Wheezes were present on auscultation of the chest and tenderness was present over the lower thoracic and upper lumbar spine. Neurologic examination was essentially normal except for mild weakness of both lower extremities. The patient was also noted to be uncomfortable with movement of the trunk.

Laboratory work included electrolytes, SMA-12, and urinalysis which were normal. Urinalysis showed rare white blood cells, but no bacteria or other sediment. Acid phosphatase was normal and alkaline phosphatase was slightly elevated at 201 U/L. Chest x-ray had changed compared to the film done two months earlier and now demonstrated a bilateral interstitial pattern with a normal heart size. Electrocardiogram confirmed that the cardiac rhythm was atrial fibrillation. CT scan of the chest documented the bilateral intestitial process but no other abnormalities. Bone scan showed increased isotope concentration at T-11, T-12 and L-1. Sputums collected for diagnostic studies showed no evidence of malignancy, but were positive when stained for acid fast bacilli (AFB). Culture at six weeks subsequently grew *Mycobacterium tuberculosis var. hominis.* CT of the spine documented destruction of the cancellous bone in the anterior portion of the T-11 vertebra and involvement of the right paraspinal soft tissue. There was no disc involvement of the affected vertebra.

Intense discussion and debate ensued regarding proper antituberculous chemotherapy and the necessity for surgical intervention. Finally, a regimen of triple drug therapy with isoniazid 300 mg/day, rifampin 600 mg/day, and pyrazinamide 1500 mg/day was agreed on. Unfortunately, the patient refused needle biopsy. The patient was discharged after completing 14 days of therapy with follow-up arranged in the pulmonary clinic at monthly intervals. The patient has responded with weight gain and subjective improvement. There has been improvement in his back discomfort and no neurologic deficits have developed.

Discussion

Although the incidence of active pulmonary TB has declined significantly, the number of cases of extrapulmonary TB has remained constant at approximately 4000 cases/year. The ratio of pulmonary to extrapulmonary TB is now at least 10:1.[1] Bone and joint TB accounts for 20% of extrapulmonary involvement and spinal tuberculosis represents approximately 60% of all cases of skeletal tuberculosis.[2] Kentucky remains 11th in the nation in incidence of active TB, and, in addition to our case, we confirmed three additional cases seen by the Jefferson County Department of Public Health TB Clinic in the last 18 months.

In the United States, the patient with spinal TB has an average age of 51 years. This is in contrast to the developing nations where this entity is generally a disease of children. In the often quoted studies of the British Medical Research Council on tuberculosis of the spine, the majority of patients are diagnosed under the age of ten years.[3] Obviously, extrapolation of treatment data from this group and its application to an older population should be scrutinized carefully.

The older patient usually presents with the nonspecific constitutional symptoms of chronic infection with low grade fevers, chills, and weight loss. They will commonly have pain over the involved vertebrae. The duration of symptoms prior to presentation averages 12 months. The majority, 70% to 80%, will have a positive reaction to the intermediate strength PPD skin test. Only 50% of these patients will have chest radiographs which show adnormalities consistent with current or old tuberculous disease.[4]

Paraplegia or paraparesis may be the first sign of this disease and will occur in 7% to 10% of patients. The neurologic signs can include sensory involvement, motor weakness, and nerve root compression. If posterior column signs are elicited, then it is safe to assume that the spinal cord compression is advanced.[5,6]

Kyphosis may or may not be present, occurring most often when the thoracic spine is involved and least often when the cervical vertebrae are affected. The lower thoracic and lumbar vertebrae are most likely to be involved in an adult. The lesion is usually the result of reactivation of hematogenous seeding during a prior pulmonary infection, but lymphatic spread from renal, pulmonary, or other lesions is also possible. Occasionally, vertebral involvement may be secondary to spread from a contiguous caseating lymph node. Vertebral collapse is a result of cancellous bone destruction allowing anterior or lateral wedging. The posterior vertebral body usually is spared collapse, but it can be involved in cavity formation. Approximately 70% of adults with spinal TB will also develop some degree of paravertebral abscess.[7]

The diagnosis of tuberculous spondylitis requires a high index of suspicion and the application of the proper tests to differentiate the condition from the more common cause of a destructive vertebral lesion in a person over the age of 50 years — metastatic neoplasm. The use of conventional spine films, including tomography, is the simplest and most valuable way to determine bone destruction and the number of vertebrae involved. CT scanning may show bone changes earlier than routine spine films, but is most helpful as an adjunct to conventional radiology in identifying edema, soft tissue involvement, and paravertebral abscesses. This modality can also be used in directing needle biopsy for tissue diagnosis. Unfortunately, CT scanning is less helpful in demonstrating abnormalities within the spinal canal.[8] Other diagnostic imaging modalities are less useful or still poorly tested (Table 1).

After the vertebral lesion has been identified, needle biopsy is essential to rule out metastatic neoplasm and allow cultural confirmation of tuberculosis. The number of *Mycobacterium tuberculosis* organisms in the bone tends to be significantly lower than that seen with the lesions of active pulmonary TB. While this suggests that successful treatment with antituberculous chemotherapy may be simpler, it also implies that special care is required in obtaining and processing the culture material. Obviously, pus or caseous material would be expected to yield a greater number of viable bacilli of *M tuber-*

Table I
Imaging techniques in Pott's Disease.

Plain Radiographs	Initial procedure of choice. (16)
CT of Spine	Improved identification of soft tissue abscess, to detect small defects in vertebral bodies, to exclude disc involvement. (17)
Bone Scan	False negatives in approximately 35% of cases of spinal tuberculosis. (18)
Gallium Scan	False negative in as many as 70% of cases of spinal tuberculosis. (19)
Leukocyte Scintigraphy	Not suitable for diagnosing bacterial inflammatory diseases in the spinal column. (20)
MRI	Improves delineation of any communication of vertebral and paravertebral inflammation. Further experience needed. (21)

culosis than bone or intervertebral disc specimens. Multiple specimens, including caseous material whenever possible, should be sent to the microbiologist. Direct smears are rarely diagnostic (30%) due to the scanty numbers of bacilli[9] and definitive diagnosis will usually require a positive culture. The selective liquid Kirchner medium should be used in addition to the usual Lowenstein-Jensen (LJ) medium to improve the efficiency of growing the scanty colonies obtained at biopsy. Kirchner liquid medium yields cultures of TB about twice as often as the usual LJ medium. Finally, and most importantly, the cultures should be incubated for a minimum of nine weeks, which is slightly longer than we are accustomed to waiting for growth from a pulmonary focus of infection.[10] Recovery of an acid fast bacillus from the needle biopsy is fairly specific for *M tuberculosis,* since atypical mycobacteria rarely cause spinal tuberculosis (three cases in the English literature).[11] Also of interest to the practitioner is the knowledge that drug resistant tuberculous organisms are extremely unusual from a spinal lesion.

With major advances in antituberculous chemotherapy has come the hope that spinal TB could be approached and treated without surgical intervention or debridement. Data to support achievement of therapeutic isoniazid levels in bone lesions in man has been encouraging, but similar data for ethambutol and rifampin have not been well documented.[4] With the success of a two-drug therapy in the treatment of active pulmonary tuberculosis, using isoniazid 300 mg/day and rifampin 600 mg/day, has come a great deal of interest in applying the same antituberculous agents for extrapulmonary tuberculosis. The American Thoracic Society and the Centers for Disease Control issued a combined official statement recommending that extrapulmonary TB be treated with the same principles and antituberculous chemotherapy regimens as outlined for pulmonary TB.[12] To support this admonition they provide a single reference which is to the work of Dutt et al.[13] These investigators have pioneered the cause for two-drug and short-course therapy and have accumulated the most experience with this approach. They reported their results in extrapulmonary TB based on nine years' experience showing excellent results in most extrapulmonary lesions, with the exception of skeletal TB.[13] Of their six treatment failures, four involved spinal TB. This represented a drug treatment failure rate for spinal TB of 20% (4/21 patients). Actually, they encourage more reservation in treating TB of the spine using only two-drug therapy, and, in fact, suggest that if there is evidence of bone destruction or abscess formation then debridement and early drainage should enhance healing.

Their experience supports British observations using combination antibiotics for spinal TB. Their current opinion for conservative therapy calls for starting treatment with three drugs and continuing treatment for 18 months.[4] Surgical intervention, once a mainstay of treatment, now has a secondary role. Except for purposes of diagnosis, when needle biopsy and aspiration are unsuccessful, routine debridement is no longer required. If there is severe neurologic compromise at the time of diagnosis or if less prominent neurologic signs do not improve with

six weeks of antituberculous chemotherapy then radical resection with anterior spinal fusion should be considered to prevent irreversible neurologic deficits. Interestingly, even when these criteria are applied, approximately one-half of the patients in a recent series (57/107 patients) eventually required anterior decompression and spinal fusion.[14]

In summary, although the concept of two-drug therapy is especially attractive in this condition with a lesser concentration of acid fast bacilli, current experience with a two-drug short course regimen has a significant failure rate. Three-drug therapy should remain the initial conservative approach after the diagnosis is confirmed. Surgery should be considered as a necessary adjunct if there are progressive neurologic signs, spinal instability, or failure of medical management. Anterior decompression and spinal fusion remains the surgical procedure of choice.[15]

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Speech and Language Screening of Children from Birth to 6 Years of Age

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Screening of speech, language, and hearing is an integral part of the evaluation of pediatric patients. Suggested speech and language screening tools, in chart form, have been provided and discussed with respect to how they should be implemented and interpreted. Information on when to refer for a complete Speech and Language Evaluation has also been provided.

While most children don't speak until 10 to 12 months of age, they are preparing for their first word as early as several days after birth. How they interact with people and objects around them in the first several months of life is critical to their language and speech development, and, later in life, their academic success. In the following pages you will find a primer for speech and language development that can be used to determine if a child is acquiring these behaviors at a rate that will give the child the best possible chance for mastering communication skills.

The first 18 months of life appear to be the most critical for the development of speech, language, motor and play development (Table 1). If the developmental process during this time is interrupted for any reason, it often results in delays in any one or all of these behaviors. The first 18 months have been termed the sensorimotor period.[1] Here the child is interacting with his environment and learning how to get people and objects to help him attain goals. This period is divided into six stages. In stages one through four (birth to 10 months) the child is essentially in the reflexive stage, eg, tonic neck reflex allows the child to view objects held. Language is thought to be unintentional on the part of the child, but the adult responds to it. That is, a child will cry when he is hungry. A hunger cry is judged as being different by the parent than the cry for pain. Therefore, the parent knows to prepare the bottle for feeding rather than seeing if a visit to the doctor is necessary. When the child enters stage five (10 to 12 months) he begins to use intentional communication, first through the use of gestures and then by saying his first words. By stage six (12 to 18 months) the child will be using many different words and putting two words together to form his version of a sentence.

At the same time that speech and language concepts are being formed, the child also goes through a similar progression of play with toys and objects in his environment (Table 1). Not until stage five does the child begin to *play* with objects in the traditional sense, eg, make a doll drink. Up until that point he is mouthing, inspecting, throwing and dropping any toy put in his hand. In stage six the child is able to pretend play and use objects in different ways (using a stick as a gun). Play skills continue to develop and become more refined well into the school age years.

How the child develops language and speech skills affects play behaviors and vice versa. If a child is in stage five for play skills, one would expect his language skills to be either one stage before (stage four), one stage after (stage six), or the same stage (stage five). Only on extremely rare occasions will you find play skills and language skills more than one stage apart. When a speech-language pathologist is evaluating a young child's speech and language development both the areas of play and language are assessed. We can tell, for example, whether a non-verbal child is ready to say his first word based on whether or not his play skills are at an appropriate level for this to happen. Therefore, very young children can be assessed for speech, language, and play skills. We know how children should perform in each of these areas, no matter how rudimentary the behavior, and thus we can offer a prognosis for whether or not the child will ultimately develop good communication skills.

Children from birth to 18 months are generally evaluated with respect to their sensorimotor skills. After 18 months they are typically referred to by age level (Table 2). There are a variety of behaviors that are displayed by children at each of these age levels. Table 2 gives the reader a quick synopsis of the major behaviors that occur at each half-year level from 1 to 6 years of age. This summary is not intended to be all inclusive. It is simply a general screener from which to make decisions for referral to a speech-language pathologist for a complete evaluation.

The second column refers to Utterance Length. It ranges from a Mean Length of Utterance (MLU) of 1.0 words at 1 year of age to 6.0 words at 6 years of age.[2] An MLU is derived by obtaining a spontaneous speech sample from the child, adding the number of words used and dividing by the number of utterances (sentences).

TABLE I

Sensorimotor Stage	Communication/ Speech Behaviors	Motor/Play Behaviors
I (birth-2 mos)	Throaty noises	Grasping reflex, tonic neck reflex, gazes, stares at surroundings
II (2-4 mos)	Cooing Laughs aloud	Visually follows objects, voluntary grasp, hand-to-mouth reflex, spontaneous social smile
III (4-8 mos)	Imitates sounds in repertoire Babbling	Sits without support, crawls, palmar grasp, pulls up with help, repeats behavior to get the same result
IV (8-10 mos)	Uses jargon	Begins to drink from a cup, feeds self cracker, holds own bottle, examines toys, imitates behaviors of others
V (10-12 mos)	Indicates needs by pointing and looking at the adult Uses rising intonation Says first word Uses mostly nouns	Waves bye-bye, walks (12 mos) drops & throws toys, gives toy on request, uses toy to obtain adult attention, uses gesture to enlist adult help, plays patty-cake, pulls toy on a string
VI (12-18 mos)	Uses successive single word utterance Uses falling intonation Two word utterances begin 22 word vocabulary Uses nouns & verbs	Tries to build tower of 2 cubes (12 mos), walks (12 mos), builds tower of 2 cubes (15 mos), builds tower of 3-4 cubes (18 mos), hurls ball (18 mos), feeds self with spoon (18 mos), makes doll drink, thinks before acting, begins to pretend play (18 mos), uses a stick to retrieve objects out of reach

It should be noted that the biggest jump in MLU occurs between 2 and 2½ years of age while there is little noticeable change from 4 to 6 years of age.

Linguistic performance is the complexity of the child's utterances; that is, how the child uses grammatical markers in his language to make it more complex and diverse. This progression is a logical one, and one that appears to be universal across children. Since this table is a summary of different behaviors, not all linguistic skills are listed. It can be said, however, that most linguistic skills are mastered by the fourth year of life and the child at this level should essentially be functioning as a *little adult* in this area. Vocabulary, on the other hand, begins with the child's first words and continues to grow through childhood and on into adulthood. A child establishes the need and usage for an extensive vocabulary early in life. Vocabulary, however, is one of the many communicative behaviors that always has the potential for improvement.

Phoneme development, often called articulation development, also occurs in a predictable sequence across children. The data listed here are customary usage norms meaning that 51% of the children at that age had that particular sound.[6] There are other norms available[2,3,4,5] that represent from 51% to 90% usage. The 51% norms would be a very liberal interpretation of the data while 90% would be a conservative one. There are numerous parameters that affect articulation performance. By screening at the 51% level and making the referral for a complete evaluation, the speech-language pathologist will be able to take into account all parameters that affect a recommendation to initiate therapy. Perhaps an example would be helpful. Let's assume that a child of two is screened and fails in phoneme development. During the evaluation the clinician would investigate how this child performs on language testing, determine where he stands in birth order, evaluate whether or not he is stimulable for sounds he should be producing, determine the structure and function of the speech mechanism, inquire as to whether he has a history of chronic otitis media, etc. Based on

TABLE II

Age	Utterance Length	Linguistic Performance	Vocabulary	Phoneme Development	Parts of Speech	Play Behavior
1 yr	$\bar{x}$ 1.0	First words			Nouns	
1.5	$\bar{x}$ 1.2	Strings single words together Starts using two words	22 words		Verbs	
2 yr	$\bar{x}$ 1.7	Simple sentences	270 words	m,n,h,p,w,b	Adverbs	Solitary
2.5	$\bar{x}$ 3.1	-ing, in, on plurals	450 words	ng,k,g,d,t	Prepositions Adjectives Conjunctions Pronouns	
3 yr	$\bar{x}$ 4.1	Basic sentence types Possessives Irregular past tense	900 words	f,j,l,s,r		
3.5	$\bar{x}$ 4.5	Irregular & regular 3rd person singular Regular past tense	1200 words			Parallel
4 yr	$\bar{x}$ 5.0	Auxiliary (is, are) All adult sentences except passive	1500 words	ch,v,dz,sh		
4.5	$\bar{x}$ 5.3		1900 words			Associative Cooperative
5 yr	$\bar{x}$ 5.5		2000 words	th		
5.5	$\bar{x}$ 5.7		2300 words			
6 yr	$\bar{x}$ 6.0	Passive (The boy was hit by the girl)	2500 words	z		

the results of that investigation, therapy may or may not be recommended. Two seemingly identical children with the same phonemes in error could easily receive two entirely different recommendations based on *other* factors that relate to development.

Listed next is the category, *parts of speech*. While not all words used by children at 1 year of age will be nouns, for most children they are the majority. Typically a large number of verbs are added at 1½ years of age. Essentially all parts of speech are observed in the child's expressive language by between 2½ and 3 years of age. Scanning the chart, one can see that by the age of 4, the child has developed a significant amount of the speech and language behaviors. This is not to say that important changes don't occur after the age of 4. It simply points out how critical the early years are to good language and speech development.

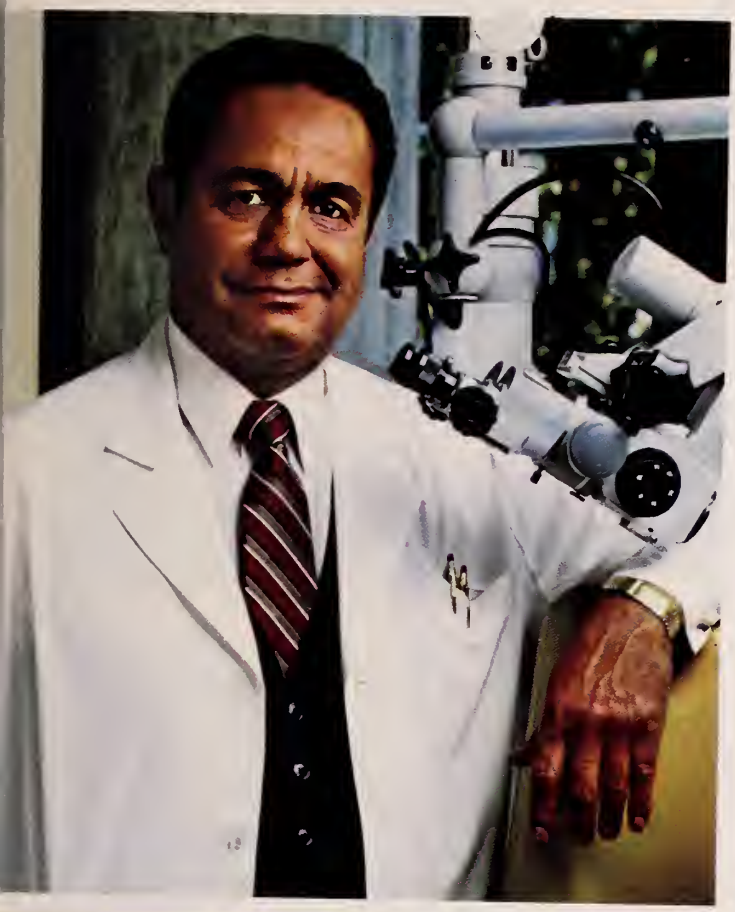
The final column is that of play behaviors. At 2 years a child engages primarily in solitary

play. The child plays alone and independently with different materials and does not interact with other children who may be in the same room. Parallel play begins to occur at 3½ years. The child continues to play independently but among other children and with their same materials. Play is beside rather than with other children. At 4½ years of age children begin associative and cooperative play behaviors. In associative play the child engages in group participation and often communicates during the interaction. Play is not organized around a goal as the most important aspect appears to be associations with the other children. Cooperative play, on the other hand, requires that the child play with other children, always working toward a common goal. As in the sensorimotor period, the development of good play skills enhances good linguistic skills and vice versa. The child begins as an onlooker with play, using no communication, and progresses to goal-oriented play which requires sophisticated communication skills for completion. If the child fails to play appropriately, the other children will penalize him for that behavior. If communication skills are inappropriate, the final goal may not be realized.

As you might guess from the above descriptions, the relationships among speech, language, motor and play development are intricate. All of these behaviors are critical for developing good communication skills, and good communication skills are necessary for successful academic performance. The nurse practitioner routinely performs speech and hearing screenings on children when they visit the physician for check-ups. While it is difficult to give a definite age differential to use as a cutoff for referral, a conservative approach would be to refer for complete testing when the child performs six months behind chronological age. The speech-language pathologist can then administer in-depth speech and language testing to determine if therapy is indicated. The descriptions and screening forms provided for you in this article will hopefully prove to be helpful in making these referral decisions. Your participation in the early diagnosis of speech or language problems will play an integral part in assuring that the child will have the best possible chance for communicative and academic success.

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Dr. Tipton and residents examining post-operative patient in recovery room.

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Contraindication: Axid is contraindicated in patients with known hypersensitivity to the drug and should be used with caution in patients with hypersensitivity to other H_2-receptor antagonists.

Precautions: *General*—1. Symptomatic response to nizatidine therapy does not preclude the presence of gastric malignancy.

2. Because nizatidine is excreted primarily by the kidney, dosage should be reduced in patients with moderate to severe renal insufficiency.

3. Pharmacokinetic studies in patients with hepatorenal syndrome have not been done. Part of the dose of nizatidine is metabolized in the liver. In patients with normal renal function and uncomplicated hepatic dysfunction, the disposition of nizatidine is similar to that in normal subjects.

Laboratory Tests—False-positive tests for urobilinogen with Multistix® may occur during therapy with nizatidine.

Drug Interactions—No interactions have been observed between Axid and theophylline, chlordiazepoxide, lorazepam, lidocaine, phenytoin, and warfarin. Axid does not inhibit the cytochrome P-450-linked drug-metabolizing enzyme system; therefore, drug interactions mediated by inhibition of hepatic metabolism are not expected to occur. In patients given very high doses (3,900 mg) of aspirin daily, increases in serum salicylate levels were seen when nizatidine, 150 mg b.i.d., was administered concurrently.

Carcinogenesis, Mutagenesis, Impairment of Fertility—A two-year oral carcinogenicity study in rats with doses as high as 500 mg/kg/day (about 80 times the recommended daily therapeutic dose) showed no evidence of a carcinogenic effect. There was a dose related increase in the density of enterochromaffin-like (ECL) cells in the gastric oxyntic mucosa. In a two-year study in mice, there was no evidence of a carcinogenic effect in male mice, although hyperplastic nodules of the liver were increased in the high dose males compared to placebo. Female mice given the high dose of Axid (2,000 mg/kg/day, about 330 times the human dose) showed marginally statistically significant increases in hepatic carcinoma and hepatic nodular hyperplasia with no numerical increase seen in any of the other dose groups. The rate of hepatic carcinoma in the high dose animals was within the historical control limits seen for the strain of mice used. The female mice were given a dose larger than the maximum tolerated dose, as indicated by excessive (30%) weight decrement compared to concurrent controls, and evidence of mild liver injury (transaminase elevations). The occurrence of a marginal finding at high dose only in animals given an excessive, and somewhat hepatotoxic dose, with no evidence of a carcinogenic effect in rats, male mice, and female mice (given up to 360 mg/kg/day, about 60 times the human dose), and a negative mutagenicity battery is not considered evidence of a carcinogenic potential for Axid.

Axid was not mutagenic in a battery of tests performed to evaluate its potential genetic toxicity, including bacterial mutation tests, unscheduled DNA synthesis, sister chromatid exchange, and the mouse lymphoma assay.

In a two-generation, perinatal and postnatal, fertility study in rats, doses of nizatidine up to 650 mg/kg/day produced no adverse effects on the reproductive performance of parental animals or their progeny.

Pregnancy—Teratogenic Effects—Pregnancy Category C—Oral reproduction studies in rats at doses up to 300 times the human dose, and in Dutch Belted rabbits at doses up to 55 times the human dose, revealed no evidence of impaired fertility or teratogenic effect, but, at a dose equivalent to 300 times the human dose, treated rabbits had abortions, decreased number of live fetuses, and depressed fetal weights. On intravenous administration to pregnant New Zealand White rabbits, nizatidine at 20 mg/kg produced cardiac enlargement, coarctation of the aortic arch, and cutaneous edema in one fetus and at 50 mg/kg it produced ventricular anomaly, distended abdomen, spina bifida, hydrocephaly, and enlarged heart in one fetus. There are, however, no adequate and well-controlled studies in pregnant women. It is also not known whether nizatidine can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity. Nizatidine should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

Nursing Mothers—Nizatidine is secreted and concentrated in the milk of lactating rats. Pups reared by treated lactating rats had depressed growth rates. Although no studies have been conducted in lactating women, nizatidine is assumed to be secreted in human milk, and caution should be exercised when nizatidine is administered to nursing mothers.

Pediatric Use—Safety and effectiveness in children have not been established.

Use in Elderly Patients—Ulcer healing rates in elderly patients are similar to those in younger age groups. The incidence rates of adverse events and laboratory test abnormalities are also similar to those seen in other age groups. Age alone may not be an important factor in the disposition of nizatidine. Elderly patients may have reduced renal function.

Adverse Reactions: Clinical trials of nizatidine included almost 5,000 patients given nizatidine in studies of varying durations. Domestic placebo-controlled trials included over 1,900 patients given nizatidine and over 1,300 given placebo. Among the more common adverse events in the domestic placebo-controlled trials, sweating (1% vs 0.2%), urticaria (0.5% vs <0.01%), and somnolence (2.4% vs 1.3%) were significantly more common in the nizatidine group. A variety of less common events was also reported, if was not possible to determine whether these were caused by nizatidine.

Hepatic—Hepatocellular injury, evidenced by elevated liver enzyme tests (SGOT [AST], SGPT [ALT], or alkaline phosphatase), occurred in some patients possibly or probably related to nizatidine. In some cases, there was marked elevation of SGOT, SGPT enzymes (greater than 500 IU/L), and in a single instance, SGPT was greater than 2,000 IU/L. The overall rate of occurrences of elevated liver enzymes and elevations to three times the upper limit of normal, however, did not significantly differ from the rate of liver enzyme abnormalities in placebo-treated patients. All abnormalifes were reversible after discontinuation of Axid.

Cardiovascular—In clinical pharmacology studies, short episodes of asymptomatic ventricular tachycardia occurred in two individuals administered Axid and in three untreated subjects.

Endocrine—Clinical pharmacology sfudies and controlled clinical trials showed no evidence of antiandrogenic activity due to Axid. Impotence and decreased libido were reported with equal frequency by patients who received Axid and by those given placebo. Rare reports of gynecomastia occurred.

Hematologic—Fatal thrombocytopenia was reported in a patient who was treated with Axid and another H_2-receptor antagonist. On previous occasions, this patient had experienced thrombocytopenia while taking other drugs.

Integumental—Sweating and urticaria were reported significantly more frequently in nizatidine than in placebo patients. Rash and exfoliative dermafitis were also reported.

Other—Hyperuricemia unassociated with gout or nephrolithiasis was reported.

Overdosage: There is little clinical experience with overdosage of Axid in humans. If overdosage occurs, use of activated charcoal, emesis, or lavage should be considered along with clinical monitoring and supportive therapy. Renal dialysis for four to six hours increased plasma clearance by approximately 84%.

Test animals that received large doses of nizatidine have exhibited cholinergic-type effects, including lacrimation, salivation, emesis, miosis, and diarrhea. Single oral doses of 800 mg/kg in dogs and of 1,200 mg/kg in monkeys were not lethal. Intravenous LO_{50} values in the rat and mouse were 301 mg/kg and 232 mg/kg respectively.

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The Use of Lasers in the Treatment of Bladder Cancer

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Over the past decade, urologists have explored ways to treat different urological diseases with lasers. The largest clinical experience and greatest potential value of lasers in urology are in the management of transitional cell carcinoma of the bladder, especially the superficial forms of that disease. The Neodymium-YAG laser is used to destroy papillary bladder tumors which have not invaded the bladder muscle. More recently there has been increasing interest in photodynamic therapy. This involves the use of an argon pumped dye laser to illuminate the bladder, thereby activating an exogenously administered photosensitizer which is selectively concentrated in neoplastic tissue. This form of therapy should be most applicable in patients with diffuse carcinoma in situ of the bladder.

Introduction

Often, the arrival of new technology and the instruments designed to put such technology into use are accompanied by exaggerated and occasionally false claims. Unfortunately, laser technology and instrumentation are no exception. Nevertheless, when lasers are used in a manner which recognizes their shortcomings, they do bring a new dimension to our surgical capability in the treatment of bladder cancer, and they should not be dismissed as expensive, hazardous, and impractical devices. It is in the management of bladder cancer that lasers have gained the most widespread acceptance in urology. They appear to have the potential to be superior to conventional modalities of therapy especially in terms of reducing the frequency of recurrent tumors.

Bladder Cancer

Bladder cancer is the third most common malignancy among American males.[1] More than 45,000 new cases are recorded annually in the United States.[2] More than 90% of these tumors are transitional cell in origin. Transitional cell carcinoma is divided into two broad groups — superficial and invasive — based on the malignant potential and eventual prognosis. Superficial tumors constitute the majority (75% to 85%) of transitional tumors. They are mostly papillary tumors involving only the mucosa (Stage Ta) or submucosa (Stage T1)[3] (Fig 1). A minority of superficial tumors are flat in situ carcinoma (Stage Tis), and this group has a more serious prognosis because of their tendency to invade the bladder musculature and spread to distant sites.[4] Approximately 30% of patients with in situ carcinoma develop invasive bladder cancer if untreated, compared with only 10% of superficial papillary tumors.

One of the characteristics of superficial papillary bladder tumors is the tendency to recur after transurethral resection.[5] There are three reasons to explain this high recurrence rate. First, tumor cells exfoliated at the time of resection may implant at the site of resection and result in new tumors. Secondly, there is good evidence that bladder tumors tend to be multifocal in nature; and, finally, unsuspected inadequate resection may result in recurrent disease. In order to reduce this high (30% to 60%) recurrence rate, patients usually receive prophylactic intravesical therapy with chemotherapeutic agents (Thiotepa, Mitomycin C or Adriamycin) or Bacillus Calmette Guerin (BCG) following transurethral resection.[6] Diffuse carcinoma in situ, on the other hand, is not usually amenable to transurethral resection and is usually treated with the same intravesical agents.

Lasers

The physical principles of lasers are based on the quantum theory of Plank and the concept of *stimulated emission* described by Einstein. The physics of laser action have been well described elsewhere.[7] For the purposes of this discussion, a laser can be thought of as an instrument which produces a beam of photons which have a specific electromagnetic wavelength. Lasers differ from one another according to the wavelength of the photon beam they emit, and their effect on tissue depends on the wavelength. The wavelength of lasers used in medicine varies from the visible to the mid-infrared portion of the electromagnetic spectrum. The two lasers which are most commonly used in the treatment of bladder cancer are the Neodymium-YAG laser and the argon pumped dye laser.

The Neodymium-YAG laser emits electromagnetic radiation (non-ionizing) with a wavelength of 1,060 nm which is in the invisible, near infrared portion of the electromagnetic spectrum. With this laser there is significant scattering of the beam within the bladder tumor when



Fig 1. A superficial papillary transitional cell carcinoma.

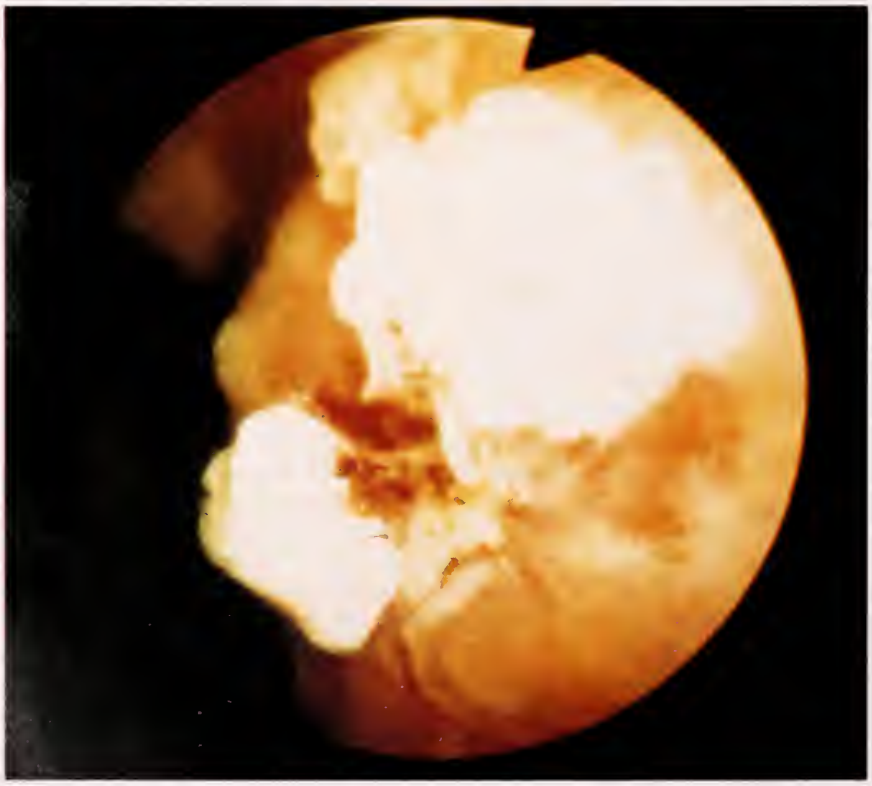


Fig 2. Superficial tumor which has been coagulated by Neodymium-YAG laser.

it is transmitted down a fiber which is passed into the bladder through a cystoscope. The laser energy is converted into heat when it strikes the tumor. This creates a thermal effect and the tissue is coagulated and destroyed (Fig 2). This laser produces a predictable uniform zone of penetration unlike electrocautery which produces an unpredictable, irregular area of damage.

The other laser we use to treat bladder tumors is the argon pumped dye laser. Unlike the Neodymium-YAG laser, this is a non-thermal laser which produces a laser beam which falls within the visible (red) portion of the electromagnetic spectrum. It produces its effect by activating an exogenously administered photosensitizer. The laser is the most effective way to produce an intense beam of monochromatic (red light — 630 nm) light which can be passed along a fiber with sufficient energy to activate the photosensitizer. This is called photodynamic therapy.

Neodymium-YAG and Superficial Tumors

For any new therapy to gain widespread acceptance it must be proven to be at least as safe, effective, and economical as the therapy it aims to replace. Hofstetter and associates have shown that greater than 90% of superficial papillary tumors can be removed with the Neodymium-YAG laser with a negligible complication rate.[8] This is comparable to results with transurethral resection. The main advantage of the Neodymium-YAG laser over transurethral resection is the reduction in the recurrence rate due to implementation of tumor cells in the bladder. This was felt to be a theoretical advantage until a recent report by Beisland and Seland in which they compared laser destruction with transurethral resection.[9] This was a prospective randomized study, and it confirmed other studies which used historical control data (Table 1). The reason for the lower local recurrence rate is thought to be due to the non-contact nature of laser therapy that reduces the number of exfoliated tumor cells which could cause recurrent tumors at the same site in the bladder.

In addition, there are several other advantages with laser destruction of bladder tumors compared with transurethral resection. The treatment can be performed as an outpatient procedure since it is carried out under local anesthesia, is associated with negligible bleeding, and does not require a catheter. Also, the actual cost of the procedure is less than half that of tran-



Fig 3. Superficial papillary tumor prior to photodynamic therapy.

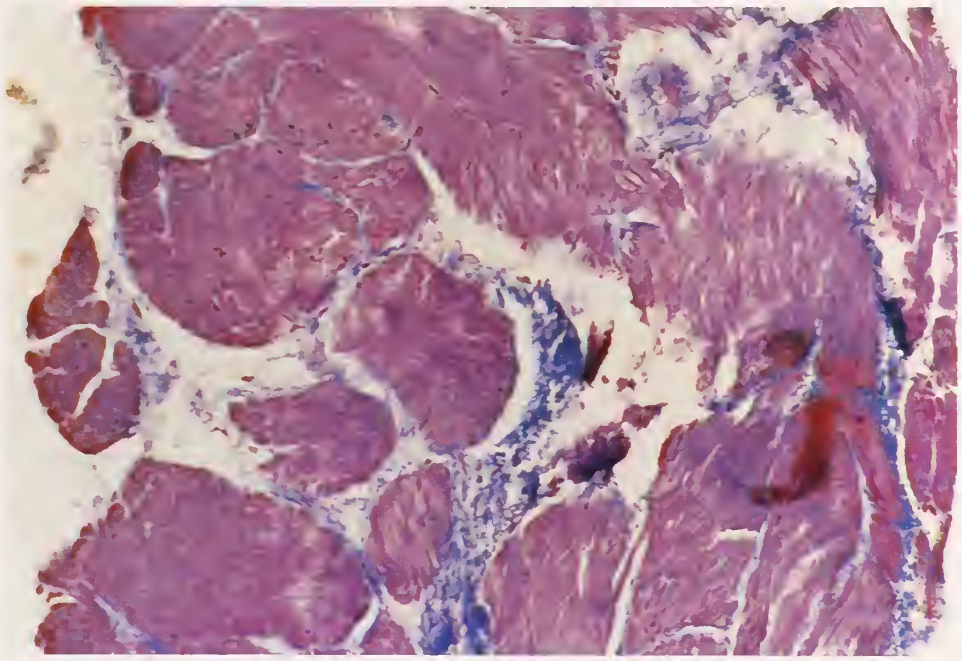


Fig 5. Muscle biopsy of bladder prior to PDT. Trichrome stain shows pink muscle and blue collagen — X400.



Fig 4. Papillary tumor post PDT showing congestion. The tumor subsequently necrosed.

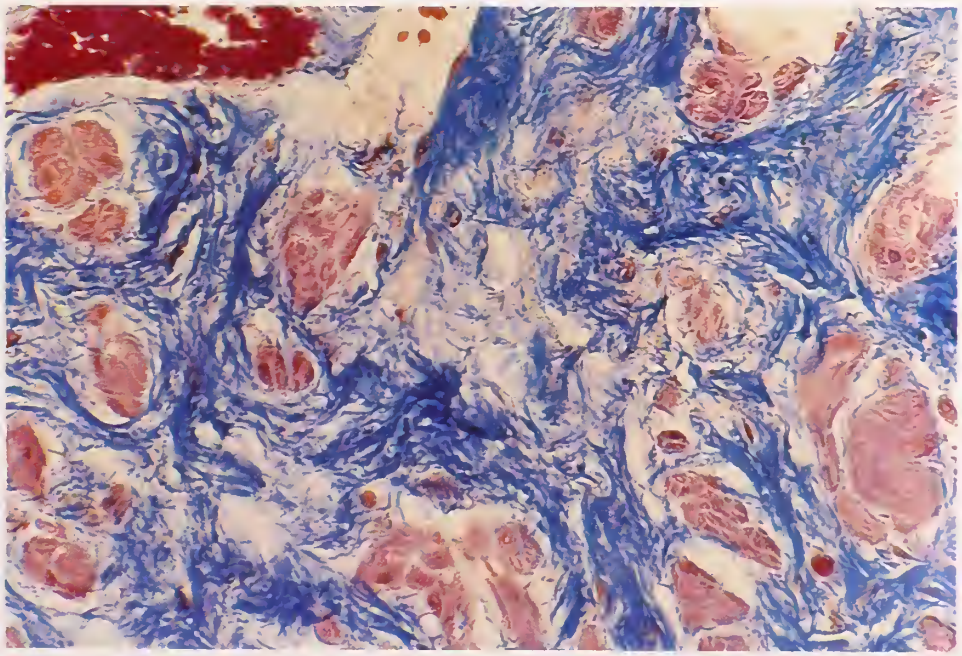


Fig 6. Muscle biopsy of bladder post PDT. Trichrome stain shows considerable loss of muscle which has been replaced by fibrous tissue — X400.

TABLE I
Recurrence Rates Following Laser Versus TUR

Breisland — 122 patients

	No. Pts.	Local	2nd Site	Combined
Laser	62	3/62 (5)	12/62 (20)	15/62 (25)
TUR	60	19/60 (30)	11/60 (22)	30/60 (50)

TABLE II
PDT for Diffuse Tis (Alone)

Investigator	No. Patients	Success	Failure
Hisazumi[13]	1	1	0
Nseyo[14]	1	1	0
Shumaker[15]	12	11	1
Benson[16]	8	8	0
Jocham[17]	5	4	1
Harty[12]	2	1	1
	29	26	3

surethral resection which requires anesthesia and a short (1-2 day) hospital stay. This is obviously important for the patients as they may require several examinations and treatments per year. These advantages must be weighed against the initial cost of the laser, the hazards to both patient and hospital personnel if the laser is incorrectly used, and the lack of tissue for histology.

There is little role for the Neodymium-YAG laser in the management of invasive bladder tumors. These tumors should be treated with either a partial or total cystectomy depending upon their location within the bladder. However, for patients who are at too high a risk to undergo a major open surgical procedure, Neodymium-YAG laser has been used to control bleeding and also to attempt to achieve a cure by inducing a full thickness thermal destruction of the tumor.

Laser Induced Photodynamic Therapy

Photodynamic therapy is an experimental form of anti-cancer therapy which involves the action of light on exogenously administered photosensitizers — usually hematoporphyrin derivative (HPD) or dihydroporphyrin ether (DHE). It has been used to treat a wide variety of tumors.[10] The photosensitizer is administered intravenously and after waiting 72 hours, in order to allow the sensitizer to be selectively retained by the tumor, red light (630 nm) from the argon pumped dye laser is transmitted along a thin (400 micron) fiber through the cystoscope to illuminate the bladder. Activation of the photosensitizer results in the conversion of molecular oxygen to singlet oxygen which is a toxic oxygen radical capable of destroying tumor cells directly and indirectly by its effect on the microcirculation of the tumor. This form of therapy is used primarily for patients who have diffuse transitional carcinoma in situ. Since this form of cancer is not suitable for either the Neodymium-YAG laser or transurethral resection, the standard treatment for these patients presently is intravesical therapy, either chemotherapy or BCG. The advantages that photodynamic therapy might offer over intravesical chemotherapy are the following. First, it should provide a high therapeutic ratio; that is, the tumor should be destroyed but normal tissue spared.

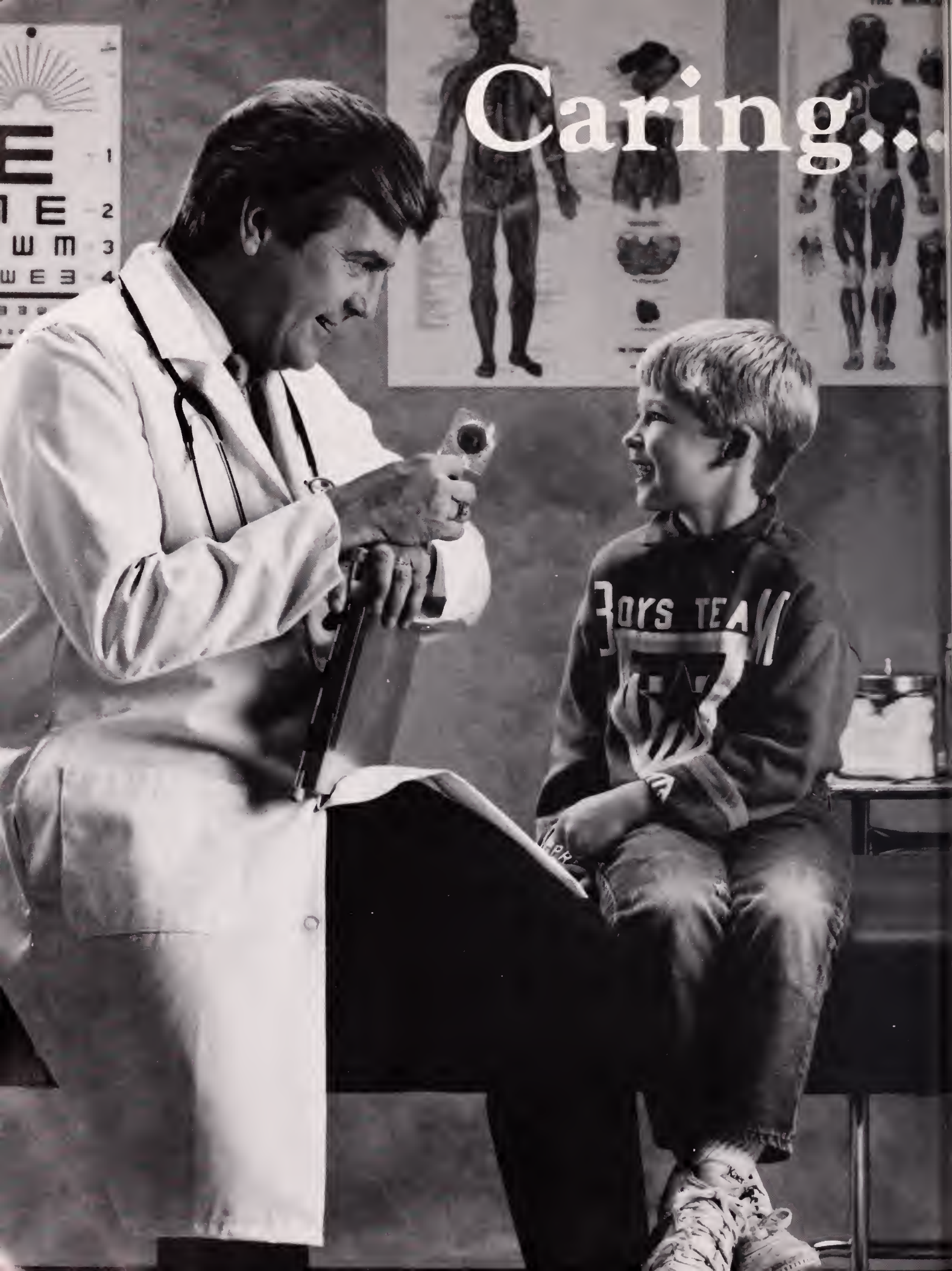
Secondly, it would be a one-time treatment compared with a weekly course of intravesical therapy for at least six weeks followed by monthly maintenance therapy for up to two years; and, finally, it might improve the results provided by intravesical therapy. We have participated in an FDA approved trial of photodynamic therapy for superficial bladder tumors.[12] We treated seven patients, two of whom had carcinoma in situ (Tis) alone. All patients were treated with whole bladder illumination, and those with papillary tumors received additional therapy to the individual tumors. Two patients were failures (1 with Tis). However, by one year following therapy, two patients had a recurrence. A review of the results with photodynamic therapy in patients with diffuse carcinoma in situ (Tis) alone shows a success rate of close to 90% (Table 2). The recurrence rate in this group is not meaningful because of the small number of patients and the short followup. Those with papillary tumors also had a good response (Figs 3, 4) but it is clear that these tumors can be more readily treated by either Neodymium-YAG laser or transurethral resection.

However, photodynamic therapy was associated with significant complications in this group of seven patients. Almost all had skin phototoxicity when they exposed themselves to light early after treatment. All had increased irritative bladder symptoms but the most serious finding was that four patients developed a contracted bladder, vesicoureteral reflux and hydroureteronephrosis which has persisted more than one year after therapy. Biopsies of bladder muscle shows loss of muscle and replacement with fibrous tissue (Figs 5, 6). Based on these results, we believe that photodynamic therapy is not sufficiently refined for safe and reliable treatment of carcinoma in situ. It should be reserved for those patients who have been treated with, but failed to respond to, intravesical therapy and are facing a cystectomy.

In summary, the role of lasers in the management of bladder cancer is still not well defined. The Neodymium-YAG laser does have a role to play in the management of superficial bladder tumor especially in terms of reducing recurrence. However, photodynamic therapy should be viewed with caution in the management of carcinoma in situ and it should not be used as a first line of therapy.

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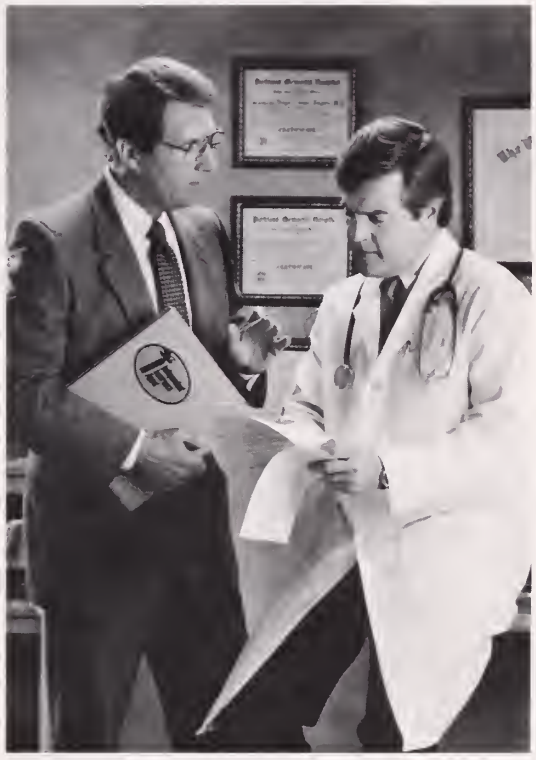

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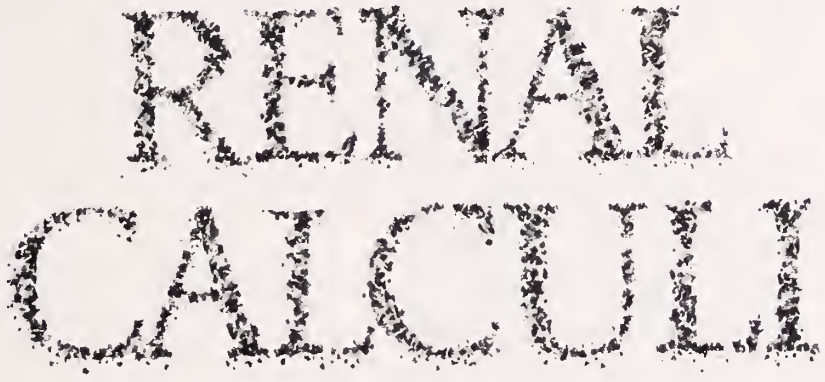
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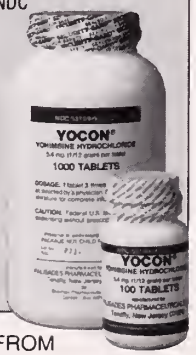
Contraindications: Renal diseases, and patient's sensitive to the drug. In view of the limited and inadequate information at hand, no precise tabulation can be offered of additional contraindications.

Warning: Generally, this drug is not proposed for use in females and certainly must not be used during pregnancy. Neither is this drug proposed for use in pediatric, geriatric or cardio-renal patients with gastric or duodenal ulcer history. Nor should it be used in conjunction with mood-modifying drugs such as antidepressants, or in psychiatric patients in general.

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Dosage and Administration: Experimental dosage reported in treatment of erectile impotence.[1,3,4] 1 tablet (5.4 mg) 3 times a day, to adult males taken orally. Occasional side effects reported with this dosage are nausea, dizziness or nervousness. In the event of side effects dosage to be reduced to ½ tablet 3 times a day, followed by gradual increases to 1 tablet 3 times a day. Reported therapy not more than 10 weeks.[3]

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I am tired of insurance companies, Medicare representatives, even my own peers, telling me whom I can admit, how long the patient should stay, and why didn't I do telemetry, peak and trough levels, or get social service on the case at day one.

The reasons for the interference are clear enough. The government and insurance companies try to exercise control of hospital utilization in an effort to control costs. The problem of course is that control of hospital utilization should only be exercised by the one willing to take responsibility for what happens to the patient. All decisions, clinical or otherwise, are easy in retrospect. Most are not so simple initially. Post hospital criticism or denial of benefits is cynical, unrealistic, and borders on the amoral.

I have no answers to the problems. I do have some predictions. There will be fewer doctors willing to practice primary care in the future — internists, family practitioners, pediatricians, obstetricians, and surgeons. The care practiced will be split responsibility. I work 9 to 5 this week, you cover nights, and no one has the final responsibility for the patient. An irresponsible approach is inevitable.

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AKMA Kept On The Right Track

Anyone wishing information about the Auxiliary to the Kentucky Medical Association should contact: Carol Franks, President 3595 Sherwood Rd, Paducah, KY 42001 (502) 444-6092, or Jean Wayne, Executive Secretary, 3532 Ephraim McDowell Drive, Louisville, KY 40205 (502) 459-9790.

Pamela H. Potter, AKMA's 1987-88 President, challenged the Auxiliary to let "Today's Visions Become Tomorrow's Realities." She set specific goals of increase in AMA-ERF contributions and membership, training of volunteer AIDS educators, and help in securing passage of tort reform legislation in Kentucky in 1988. During the AMAA Annual Meeting held June 26-29 in Chicago, Mrs. Potter proudly accepted the awards achieved in AMA-ERF and membership.

AMAA President Mrs. Betty Szewczyk presented to the American Medical Association Education Research Foundation a check for nearly two million dollars from the Auxiliary. Kentucky was vital in the impressive amount given.

The AKMA was recognized as the state auxiliary with the *second* largest per capita contribution in the nation ($49.52). Last year AKMA received the same award for *third* highest. The AKMA was also recognized for its contribution in excess of $50,000 — actual amount being $50,758.24. Only nine state auxiliaries received this award! AMA-ERF State Chairman Mrs. Pam Blackstone kept all counties on the right track to produce this result.

How proud to see Mrs. Potter accept the next award for her home county. The Auxiliary to the Boyd County Medical Society was recognized as the county with the *second* largest per capita contribution in the nation ($224.60). Since 1984, Boyd County, under the very capable leadership of Mrs. Eloise Meigs, has been recognized for having the highest per capita contribution in the nation two times and the second highest per capita three times.

The Auxiliary to the Boyd County Medical Society was also recognized for its contributions in excess of $10,000.00 ($16,171.00).

With only 17 states receiving this award, the AKMA was very proud to be recognized for 75% or more federated membership. Plans to increase AKMA membership for 1988-89 became very serious when a membership challenge from Virginia was accepted for greatest number of members increase. "The Challenge of the Carol's is on," says AKMA president *Carol* Franks and Virginia's Auxiliary President *Carole* Lougheed.

AKMA's visions became realities only through the dedicated support and commitment of hundreds of county auxilians throughout the state. It was with great pride that these awards were accepted on behalf of all those who worked so hard to earn them.

Carol Franks
AKMA President



Kentucky auxilians attending the AMAA Annual Meeting included (seated L to R) Pam Blackstone, Esther Jansing, Jo-Anne Daus, Pam Potter, and Carol Franks; (standing L to R) Marna Loucks, Beverly Myers and Gloria Griffin.

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Roger Jackson, M.D., Kansas City
John Sergent, M.D., Nashville

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Highlights of Emergency Medical Care Seminar



E. Truman Mays, MD, Somerset, Chairman of the KMA Emergency Medical Care Seminar Committee.





William C. DeVries, MD, Louisville, middle photo, and John C. Hunsaker, MD, Lexington, bottom photo, were among the many fine speakers participating in the Seminar.

The 18th Annual KMA Emergency Medical Care Seminar returned to Louisville this year with more than 400 people attending the meeting. Faculty for the three-day meeting included Kentucky physicians, nurses, EMTs and paramedics.

This year's themes included: "Pediatric Emergencies" and "Medical Neurologic Emergencies."

Next year's meeting will be held in Louisville at the Executive West, May 16, 17, and 18.



Cheryl Westbay, RN, CEN, and Ree Murakami, RN, CEN, were the 1988 recipients of the Outstanding Dedication Award from the Kentucky Emergency Nurses Association.



Participants listen to Doctor Mays at one of the sessions.





The ambulance competition and helicopter displays always provide the latest techniques for emergency care.



One of the many interesting exhibits at the Seminar.



KMA Vice President Nelson B. Rue, MD, left, moderator for one of the sessions, is shown with Frank W. Lavoie, MD, Louisville, a guest luncheon speaker.

Physician's Recognition Award Recipients

Listed below are KMA member physicians in Kentucky who have earned the AMA's Physician's Recognition Award (PRA) from September 1987 through June 1988.

The Award was established by the AMA House of Delegates of the American Medical Association in 1968 "to encourage physician participation in continuing medical education and to recognize physicians who have voluntarily completed programs of continuing medical education." A minimum of 150 credit hours of CME must be earned over a consecutive 3-year period to qualify for the Award. Of these 150 hours, at least 60 must be in AMA/PRA Category 1. Ninety hours of education can be in Category 2 which includes CME lectures and seminars not designated Category 1; medical teaching; articles, publications, books, and exhibits; and non-supervised CME such as self-instruction, consultation, patient care review, and self-assessment. Credit hours are based on hour-for-hour participation in a continuing medical education activity with the number of hours rounded to the nearest whole hour.

We congratulate the following physicians who have distinguished themselves and their profession by their commitment to continuing education:

Harry Ewing Altman, MD, Pikeville
Mohammad Amin, MD, Louisville
Christine Alice Asher, MD, Trenton
Jonathon Baldwin, MD, Corbin
David Laun Barrett, MD, Murray
James Anthony Baumgarten, MD, Louisville
Joseph Wendell Blevins, MD, Louisville
Mark Rue Campbell, MD, Trenton
George P. Carter, MD, Louisa
John P. Casey, MD, Louisville
Ralph Louard Cash, Jr, MD, Princeton
Walter L. Cawood, MD, Ashland
Henry F. Chambers, MD, Campbellsville
Donald Wayne Chandler, MD, Madisonville
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Charles Glyndon Click, MD, Stanford
Norman Moore Cole, MD, Louisville
James Melvin Collier, MD, Lexington
William Berry Cook, MD, Prestonsburg
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Hal Michael Corwin, MD, Louisville
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Arthur Theodore Daus, MD, Louisville
Gregory James Davis, MD, Louisville
Dolph Martel Denny, MD, Louisville
Hugh Kendrick Dougherty, MD, Hopkinsville
Marion A. Douglass, MD, Magnolia
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Karl Crisler Kelty, MD, Lexington
Andrew T. Kim, MD, Paducah
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Jerome L. Krumpelman, MD, Richmond
Benjamin Kutnicki, MD, Warsaw
Gertrude Ann Moore, MD, Lexington
Leonidas Mostowycz, MD, Lexington
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William N. Nash, MD, Louisville
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Thomas Kirk Slabaugh, MD, Lexington
Stephen Zalmon Smith, MD, Louisville
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Thomas Edward Topper, MD, Madisonville
Danielle M. Turns, MD, Louisville
Terry Whitmer Tyler, MD, Owensboro
Frank Patrick Vannier, MD, Louisville
Corazon Aquilar-Veza, MD, Elizabethtown
Gary Jackson Wahl, MD, Owensboro
Byran Pope Warren, MD, Owensboro
Jeffrey Alan Weiss, MD, Louisville
George Henry White, Jr, MD, Louisville
Wayne Evan Williams, MD, Mayfield
William Orin Witt, MD, Lexington
Richard Stanley Wolf, MD, St. Matthews

Nelson B. Rue, MD, Nominated for KMA President-Elect



Nelson B. Rue, MD, a general surgeon from Bowling Green, has been nominated by the Warren County Medical Society for the office of President-Elect of the Kentucky Medical Association.

Doctor Rue, a native of Franklin, Tennessee, received his Bachelor of Science degree from Western Kentucky University, his medical degree from the University of Louisville in 1956, and interned at St. Elizabeth Hospital in Dayton, Ohio. He had one year of surgical residency at Louisville General Hospital in 1959. Doctor Rue completed his residency at Wilford Hull USAF Hospital in San Antonio, Texas, and passed the American Board of Surgery while in the service.

Active in organized medicine for many years, Doctor Rue is a member of the Warren County Medical Society, Kentucky Medical Association, American Medical Association, American College of Surgeons, American and Kentucky Societies of Gastronintestinal Endoscopy and is a Diplomate of the American Board of Surgery. He served KMA as 6th District Trustee from 1981-1987; Chairman of the Board of Trustees 1984-1987; and currently serves as Vice President and Chairman of the Trends Committee. He practices at Graves-Gilbert Clinic in Bowling Green.

Doctor Rue and his wife, Sue, have five children and eight granddaughters.

Rural Kentucky Medical Scholarship Fund, Inc.



Carolyn H. McKinley, MD, President of the Rural Kentucky Medical Scholarship Fund, Inc.

The Board of Directors of the Rural Kentucky Medical Scholarship Fund, Inc. held its forty-second annual meeting on May 19, 1988, at the Kentucky Medical Association. Carolyn H. McKinley, MD, as President, presided over the meeting, which was well attended.

The Fund becomes increasingly more important each year. According to a recent article published by the AMA, the number of rural physicians in this country could drop by as much as 25% in the next five years.

For the school term 1988-89, the RKMSF loans have been increased to $7,500, and the interest rate is 4.25%. Eleven new applicants were interviewed in April, and eight renewal requests were received. Six recipients are entering approved primary care residency programs; 14 are currently enrolled in primary care residency programs; and eight recipients are entering practice in 1988. Eleven physicians received forgiveness of loans in 1987-88 for practicing in critically underserved counties.

The Fund has initiated an Establish Practice Grant Program, which will offer grants to defray the educational debts of two physicians each year who will practice in a critically underserved county in the state. This is a pilot program in addition to the RKMSF financial assistance to medical students, who are required to practice a year in a rural county for each loan received. The purpose of both programs is to alleviate the maldistribution of physicians in Kentucky.

Plaques were displayed to be presented to Mr. Bobbie Grogan and Carl Cooper, Jr, MD, who resigned from the Board of Directors. Mr. Grogan and Doctor Cooper will be remembered for their dedication and service to the RKMSF. Mr. Grogan had been affiliated with the Fund for thirty years, at one time as Executive Secretary. The Fund's success has been based on the dedication of the members of the Board of Directors and the continued support and assistance from the Kentucky Medical Association.



The RKMSF Board of Directors.

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In Memoriam

List of deceased physicians available to the Journal for the period August 1, 1987, through July 31, 1988.

Robert Hughes Scobee, MD
Winchester
1900-1987

Robert Hughes Scobee, MD, a retired general practitioner, died August 25, 1987. A 1926 graduate of the University of Cincinnati College of Medicine, Doctor Scobee was a life member of KMA.

Lyle C. Franz, MD
Maysville
1911-1987

Lyle C. Franz, MD, a retired pediatrician, died September 3, 1987. A 1938 graduate of the University of Louisville School of Medicine, Doctor Franz was a life member of KMA.

Branham Beazley Baughman, MD
Frankfort
1904-1987

Branham Beazley Baughman, MD, a retired surgeon, died September 15, 1987. Doctor Baughman graduated from the University of Michigan Medical School in 1929 and was a life member of KMA.

David H. Dorton, Jr, MD
Louisville
1916-1987

David H. Dorton, Jr, MD, a retired ophthalmologist, died September 19, 1987. A 1943 graduate of the University of Louisville School of Medicine, Doctor Dorton was a life member of KMA.

Kearney Roark Adams, MD
Liberty
1911-1987

Kearney Roark Adams, MD, a retired general practitioner, died September 25, 1987. Doctor Adams was a 1945 graduate of Long Island College of Medicine and was a life member of KMA.

Allie Everett Howe, MD
Alexandria
1896-1987

Allie Everett Howe, MD, a retired general practitioner, died October 5, 1987. A life member of KMA, Doctor Howe graduated in 1920 from Eclectic Medical College.

Thomas Paul Walsh, MD
Louisville
1911-1987

Thomas Paul Walsh, MD, a retired ophthalmologist and ENT specialist, died October 31, 1987. Doctor Walsh graduated from the University of Louisville School of Medicine in 1936 and was a life member of KMA.

Granville Baker Williams, MD
Eubank
1900-1987

Granville Baker Williams, MD, a general practitioner, died November 10, 1987. A 1942 graduate of the University of Tennessee College of Medicine, Doctor Baker had been a member of KMA since 1944.

Wilson Sebastian, Jr, MD
Lexington
1944-1987

Wilson Sebastian, Jr, MD, a gastroenterologist and a 1968 graduate of the University of Kentucky College of Medicine, died November 13, 1987. He was chief of staff at Lexington's Central Baptist Hospital and was an associate clinical professor at the University of Kentucky College of Medicine. Doctor Sebastian had been a member of KMA since 1975.

DeLon Perrin Hall, MD
Louisville
1897-1987

DeLon Perrin Hall, MD, a retired general surgeon and a past president of the Louisville Surgical Society, died November 28, 1987. Doctor Hall graduated in 1921 from the University of Louisville School of Medicine and was a life member of KMA.

Amado B. Estanislao, Jr, MD
LaGrange
1930-1987

Amado B. Estanislao, Jr, MD, a pathologist, died November 30, 1987. Doctor Estanislao was a physician for the Kentucky State Reformatory and a 1955 graduate of Manila Central University. He joined KMA in 1973.

Lawrence Thomas Hiltz, MD
Crestview Hills
1921-1987

Lawrence Thomas Hiltz, MD, a retired OB/GYN died December 8, 1987. A graduate of the University of Cincinnati College of Medicine in 1944, Doctor Hiltz was a life member of KMA.

Charles E. Hogancamp, MD
Paducah
1927-1987

Charles E. Hogancamp, MD, an internist and cardiologist, died December 18, 1987. Doctor Hogancamp was a 1953 graduate of Washington University and had been a member of KMA since 1970.

Raleigh Edwin Witten, MD
Louisville
1920-1987

Raleigh Edwin Witten, MD, a retired general practitioner, died December 21, 1987. Doctor Witten graduated in 1945 from the University of Louisville School of Medicine and was a past president of the St. Anthony Hospital medical staff. He joined KMA in 1952.

Robert Lich, Jr, MD
Prospect
1909-1987

Robert Lich, Jr, MD, died December 22, 1987. He retired in 1975 from the University of Louisville School of Medicine where he had been a Professor and Chairman of the Urology Department since 1948. Doctor Lich was recognized internationally for five surgical procedures and in 1951 was named a member of the Society of Genito-Urinary Surgeons, the only Kentucky urologist ever to be admitted to the honorary organization, which limits its membership to 100. A 1936 graduate of the Long Island College of Medicine, Doctor Lich was a life member of KMA.

Charles J. Bohle, MD
Paducah
1930-1987

Charles J. Bohle, MD, an OB/GYN, died December 22, 1987. Doctor Bohle graduated from Georgetown University School of Medicine in 1956 and had been a member of KMA since 1960.

Robert Hamlin Akers, MD
Louisville
1915-1987

Robert Hamlin Akers, MD, retired chief of radiology for the Veterans Administration Medical Center, died December 27, 1987. Doctor Akers graduated from the University of Louisville School of Medicine in 1939 and was a life member of KMA.

Rodney Allen Skaggs, MD
Owensboro
1945-1987

Rodney Allen Skaggs, MD, a pathologist, died January 6, 1988. A 1976 graduate of the University of Kentucky College of Medicine, Doctor Skaggs had been a member of KMA since 1979.

Robert Edward Strode, MD
Winchester
1908-1988

Robert Edward Strode, MD, an EEN&T physician, died January 6, 1988. Doctor Strode was a 1933 graduate of the University of Louisville School of Medicine and was a life member of KMA.

Michael Medley Hall, MD
Campbellsville
1907-1988

Michael Medley Hall, MD, a retired general practitioner and former Campbellsville mayor, died January 23, 1988. Doctor Hall graduated from the University of Louisville School of Medicine in 1933 and was a life member of KMA.

Stewart Graves, Jr, MD
Louisville
1925-1988

Stewart Graves, Jr, MD, an internist and past president of the Norton Hospital medical staff, died February 12, 1988. He was vice chairman and a governor of the Frontier Nursing Service and past president and member of the Kentucky Peer Review Organization. Doctor Graves was also a member of the advisory board of the Kentucky State Board of Medical Licensure and had been a member of KMA since 1955.

Chester Atherton Morris, MD
Covington
1894-1988

Chester Atherton Morris, MD, a retired general practitioner, died February 21, 1988. Doctor Morris graduated from the University of Louisville School of Medicine in 1925 and was a life member of KMA.

Molloy G. Veal, II, MD
Henderson
1920-1988

Molloy G. Veal, II, MD, a retired internist, died March 5, 1988. Doctor Veal graduated from the University of Louisville School of Medicine in 1948 and was a life member of KMA.

Robert Wintersmith Robertson, MD
Paducah
1903-1988

Robert Wintersmith Robertson, MD, a surgeon and past president of the Kentucky Medical Association from 1958 to 1959, died March 9, 1988. Doctor Robertson was a former president and chairman of the board of Kentucky Blue Cross & Blue Shield of which he was a member for 22 years. He also was a former member of the State Board of Health, former president of Excelsior Surgical Society of Florence, Italy, and was awarded the Order of the British Empire and the American Bronze Star for his Army service in World War II. Doctor Robertson was a life member of KMA.

William E. Jackson, MD
Paducah
1932-1988

William E. Jackson, MD, a retired internist, died March 23, 1988. A 1965 graduate of the University of Louisville School of Medicine, Doctor Jackson was a life member of KMA.

Naven M. Olson, MD
Ft. Myers, Florida
1923-1988

Naven M. Olson, MD, a retired anesthesiologist, died March 23, 1988. Doctor Olson graduated in 1947 from State University of Iowa College of Medicine and became a member of KMA in 1954.

Robert E. Pennington, MD
London
1910-1988

Robert E. Pennington, MD, a retired general surgeon, died March 31, 1988. Doctor Pennington served the KMA in numerous capacities, including Trustee, Chairman of the Board of Trustees, and President. He received the Distinguished Service Award from KMA in 1971. A 1936 graduate of the University of Pennsylvania School of Medicine, Doctor Pennington was a life member of KMA.

John William Sutherland, MD
Prestonsburg
1945-1988

John William Sutherland, MD, an internist, died May 7, 1988. Doctor Sutherland was a 1971 graduate of the University of Louisville School of Medicine and had been a member of KMA since 1975.

John R. Garner, MD
Herndon
1900-1988

John R. Garner, MD, a general practitioner, died May 17, 1988. Doctor Garner graduated from the University of Louisville School of Medicine in 1932 and was a life member of KMA.

Selby Evans Coffman, Jr, MD
Vashon, WA
1920-1988

Selby Evans Coffman, Jr, MD, a retired radiologist, died June 23, 1988. A 1950 graduate of the University of Louisville School of Medicine, Doctor Coffman was a life member of KMA.

Wilford Leroy Cooper, MD
Lexington
1912-1988

Wilford Leroy Cooper, MD, a retired proctologist, died June 23, 1988. Doctor Cooper graduated from the University of Texas Medical Branch in 1939 and was a life member of KMA.

William E. Bowers, Jr, MD
Harlan
1929-1988

William E. Bowers, Jr, MD, a general surgeon and chief-of-surgery at Harlan Appalachian Regional Hospital, died July 6, 1988. A 1955 graduate of Oklahoma University Medical School, Doctor Bowers became an active member of KMA in 1969.

Charles R. Taylor, MD
Frankfort
1931-1988

Charles R. Taylor, MD, a general practitioner, died July 15, 1988. Doctor Taylor graduated in 1955 from the University of Louisville School of Medicine and joined KMA in 1957.

Isadore Goldstein, MD
Louisville
1914-1988

Isadore Goldstein, MD, a retired general practitioner, died July 25, 1988. A 1938 graduate of the University of Georgia School of Medicine, Doctor Goldstein was a life member of KMA.

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STRIPERS ON LAKE CUMBERLAND — Somerset, Kentucky. Experienced licensed guide available for Stripe Bass or Trout fishing below Wolf Creek Dam. 51 lb. fish caught in 1987. All equipment furnished. Available during Fall KAFP meeting. References available. Contact Gene Collins at (606) 679-6135 or Robert G. Drake, Jr, MD, at (606) 679-1449.

SURGICAL & MEDICAL INSTRUMENTS FOR SALE — late 1800s to early 1900s, including ivory and ebony handled items, over 350 items total. Selected items & photos at La Maison Glacee, 131 N Sherrin Ave, or call for detailed list, 896-6363 10A-5P. Also interested in purchasing selected items.

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Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

October 12-13
Care of the Seriously Ill Child — The 16th Annual Fall Pediatric Surgery/ Pediatrics Symposium concerning "Acute Pediatric Emergencies," Lincoln Hotel and University Conference Center, Indianapolis, IN. Sponsored by the Indiana University School of Medicine. Contact: Jay L. Grosfeld, MD, (Symposium Director) Surgeon-in-Chief, Riley Hospital, 702 Barnhill Dr, Indianapolis, IN 46223, (317) 274-8353.

October 22
Community Symposium — "AIDS the Disease of the 80s," Hyatt Regency, Lexington. Contact: Mrs. John W. Collins, 2035 Bridgeport Drive, Lexington, KY 40502, (606) 269-3048 or 268-4554.

October 27
Health Fraud Conference, Campbell House, Lexington, KY. Sponsors include the University of Kentucky Cooperative Extension Service, Kentucky Dietetic Association, University of Kentucky School of Nursing and the Attorney General's Health Fraud Task Force. Contact: Darlene Forester, PhD, RD, University of Kentucky, 120 Erikson Hall, Lexington, KY 40506, (606) 257-1812.

November 10-11
22nd Annual Newborn Symposium, Kosair Children's Hospital Auditorium, 200 E. Chestnut St., Louisville, KY. Larry N. Cook, MD, Professor and Associate Chairman, Department of Pediatrics, will be Program Chairman. Contact: Linda S. Ecker, Academic Coordinator, Department of Pediatrics, School of Medicine, University of Louisville, Louisville, KY 40292, (502) 562-8826.

December 7-9
American Cancer Society, National Conference on Advances in Cancer Management, Hyatt Regency Hotel, Los Angeles, California. Contact: American Cancer Society, National Conference on Advances in Cancer Management, 3340 Peachtree Rd., N.E. Atlanta, GA 30026 (212) 599-3600.

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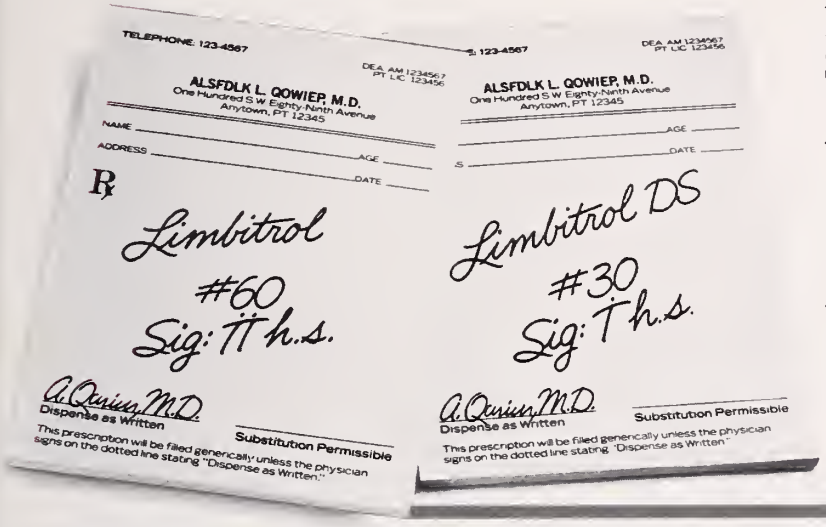
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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

Usage in Pregnancy: **Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.
Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

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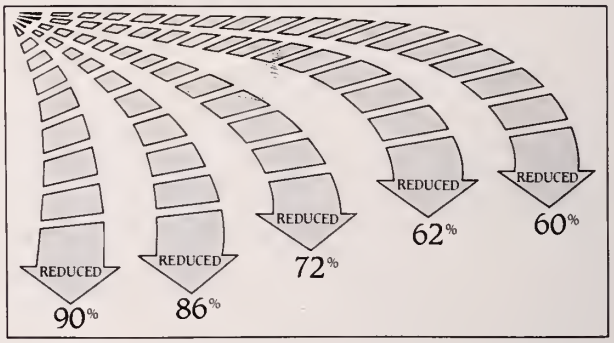
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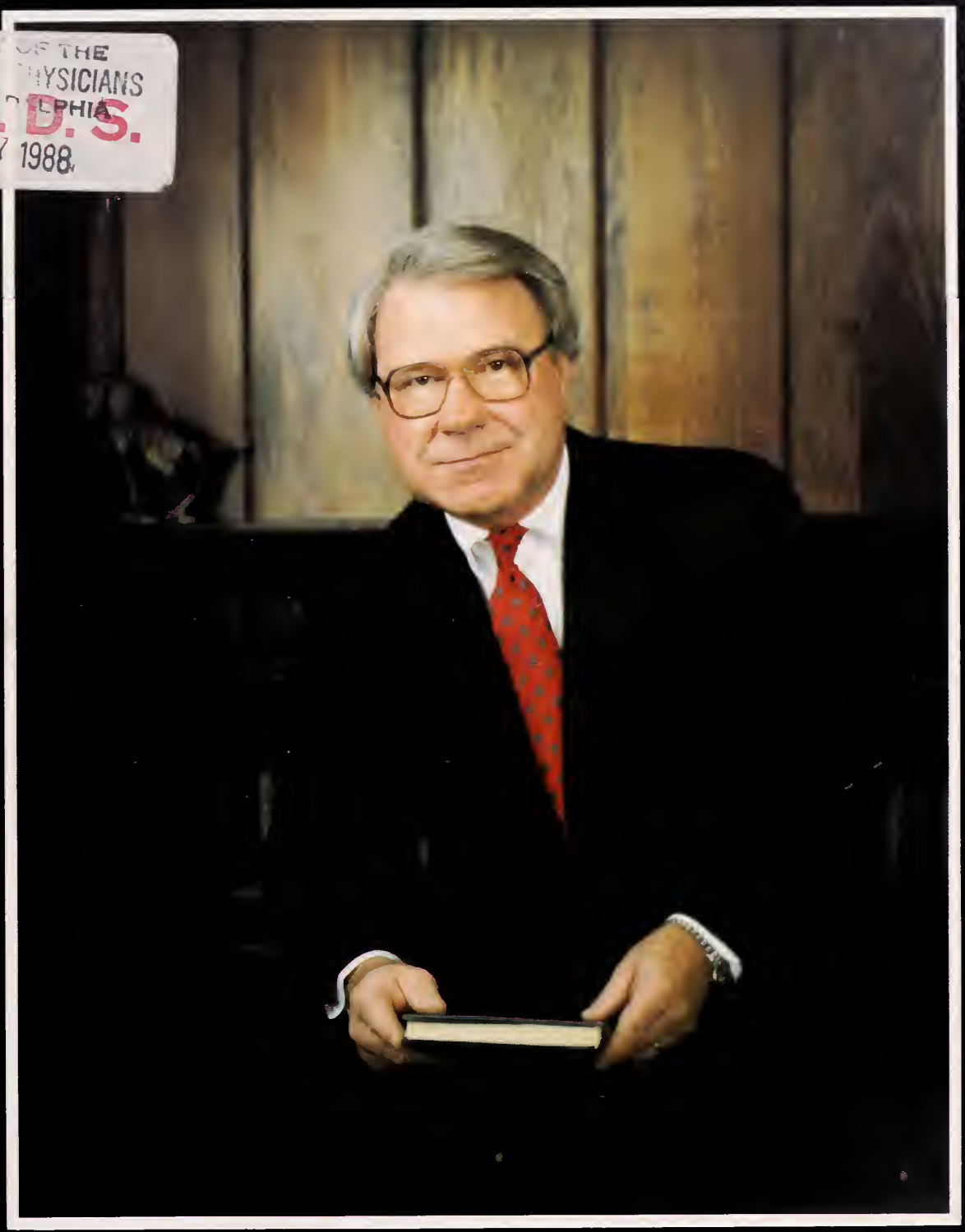


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Bob M. DeWeese, MD
KMA President

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VOL 86 NO. 10
OCT 1988

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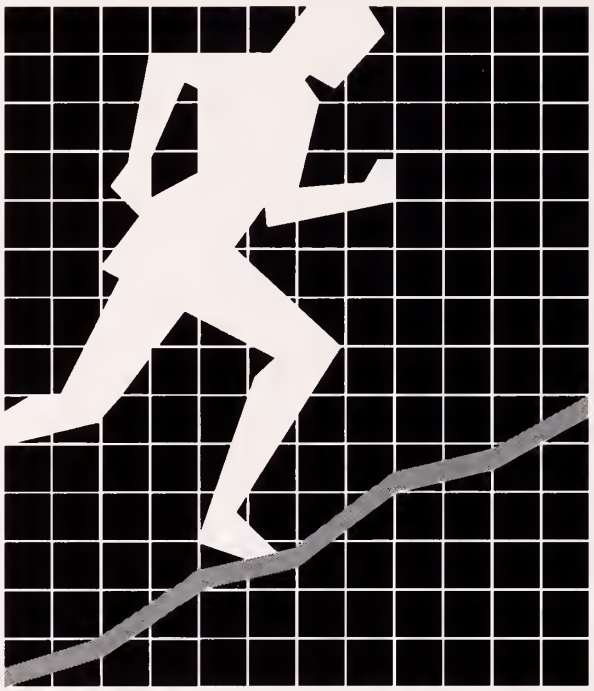
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TABLE OF

CONTENTS

October 1988

Cover:
Bob M. DeWeese, MD, Louisville, was installed as KMA's President for 1988-89 on September 28, 1988.

SCIENTIFIC

The Surgical Treatment of Wolff-Parkinson-White Syndrome
A. David Slater, MD; Joel Kupersmith, MD; Laman A. Gray, Jr, MD **551**

Subacute Encephalitis and the AIDS-Associated Organic Brain Syndrome
William G. Simpson, MD; Benjamin T. Oldham, MD **554**

Acute Intervention in Myocardial Infarction — Role of Thrombolytic Therapy and Adjuvant Angioplasty *(Grand Rounds)* **561**

EDITORIAL

SZS **577**

SPECIAL ARTICLE

KMA's 1988-89 Leader **571**

ASSOCIATION

Digest of Proceedings of August Board Meeting **580**
AMA Annual Meeting **582**
KMA Hospital Medical Staff Section Holds Annual Meeting **584**
Complaints About Fees and Costs for Medical Records and Depositions **587**

REGULAR FEATURES

President's Page **545**
Auxiliary **579**
Updates **586**
CME **589**
Classified **591**
Information for Authors **557**

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Charleston Area Medical Center 547, 559
Classified 591
Computer Links Associates, Inc. 544
KMIC 558
KMIC Investment Company 540
KMIC Leasing Company 548
Kentucky Academy of Family Physicians 588
Eli Lilly & Company 550
Medical Protective Company 575
Miles Pharmaceuticals 567, 568
Naval Reserve Force 576
PIE Mutual Insurance Company 570
Palisades Pharmaceuticals, Inc. 576
Roche Laboratories 593, 594
Signature, Inc. 569
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PRESIDENT'S PAGE

I am deeply honored to serve as your KMA President this coming year.

As I accept your KMA Presidency, I cannot help but reflect on the great men of Medicine who have preceded me in this office. I pledge to make every effort to give the same caliber of leadership that they have given. I can do it only with support from you — my fellow friends and colleagues across this great state.

Since its beginning, KMA has always made its primary goal the assurance of quality medicine for ALL of the citizens of Kentucky. In the past few years, KMA has had to deal with a great many changes that targeted our medical profession. Our leaders spent thousands of hours trying to overcome pressures and obstacles which were often created by self-interest groups, misguided politicians and untenable government regulations.

KMA has made positive attempts to make our organization more flexible to meet the demands of the current times. Many of you have helped by giving input and ideas as well as valuable advice and criticisms. You have done even more. You have given countless volunteer hours meeting with your legislators, your community leaders, and your hospital committees and peer groups in attempting to work through problems in an ethical and professional manner.

We begin this year with current stalemates. The liability crisis, the care for the elderly and indigent, and the escalating costs of medical services are problems which create a formidable agenda. There is an even greater threat for doctors who conscientiously attempt to deliver quality health care to their patients. This threat comes from the rape of our profession by *for profit* health management companies. These companies are skimming our resources and eliminating freedom of choice of physicians and medical facilities for our patients. They seem intent on dictating the practice of medicine based on an economic cookbook whose *main course* is profit. What is most objectionable is that these companies often eliminate their competitors through questionable marketing strategies and methods.

It has been said in the past that KMA's activities have been self-serving and reactionary, not innovative and not assertive. NOTHING could be further from the truth.



Every time our Association spoke out on a medical issue, our critics in the legislature and in the media judged doctors as *self-serving* professionals who were worrying about their fees and their pocketbooks. Unfortunately, we doctors often lacked the time, the courage, and the expertise to persist in demands for our profession — demands that ultimately meant the welfare of our patients. And yes, too often we doctors thought that community leaders and other professionals would give us their support and fight the issues for us. The time has now come for us to convince the public that our priority concern is the welfare of every patient in this state.

How do we go about educating and informing JOHN Q. PUBLIC? I maintain that KMA must do the following:

KMA must remain proactive in assuring that only qualified physicians can practice medicine in our state. Those who are not qualified must be re-trained, re-habilitated or re-tired.

KMA must be proactive in our quest for an equitable solution to the liability crisis.

KMA must be proactive in urging the legislature and state government officials

to have the courage to find the revenue to adequately fund our Medicaid program and Care for the Indigent and Elderly program.

KMA must be proactive in educating patients of the threats to quality care by *for profit* health companies.

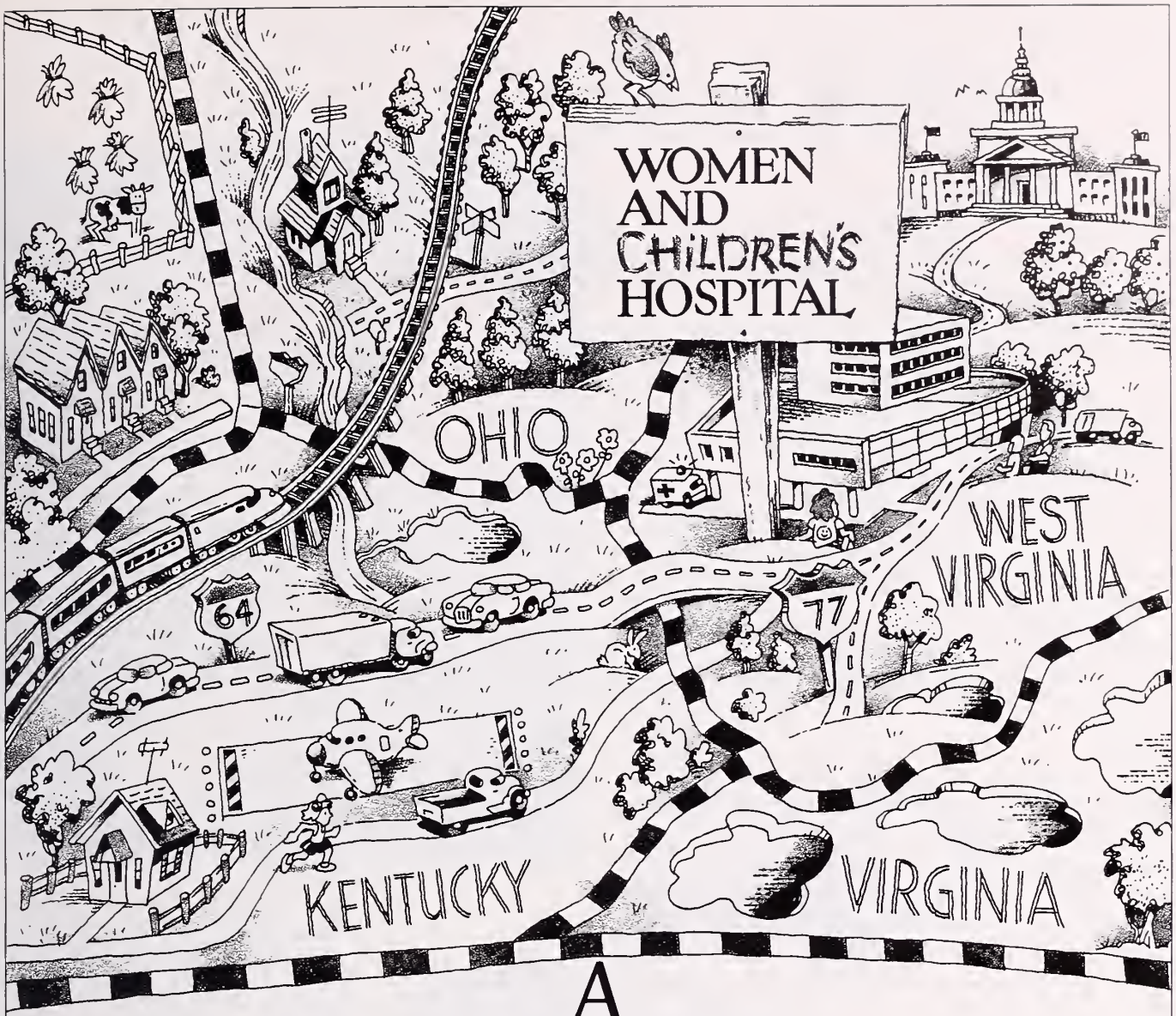
KMA must be proactive in working with State Insurance officials to insure that patients completely understand the benefits of their insurance plans.

KMA must be proactive in convincing the public that we doctors are advocates for quality health care and services for the welfare of our patients, not our own pocketbooks.

KMA must be proactive in retaining our proud professional standards and never, never be content with mediocre or inferior medical practices.

A famous historian once wrote: *Character is simply habit long continued.* I think that I can speak for the character of the Kentucky Medical Association and its members. We have always upheld the very finest principles of medical practice for those who are privileged to serve. WE will not depart from that commitment.

Bob M. DeWeese, MD
KMA President



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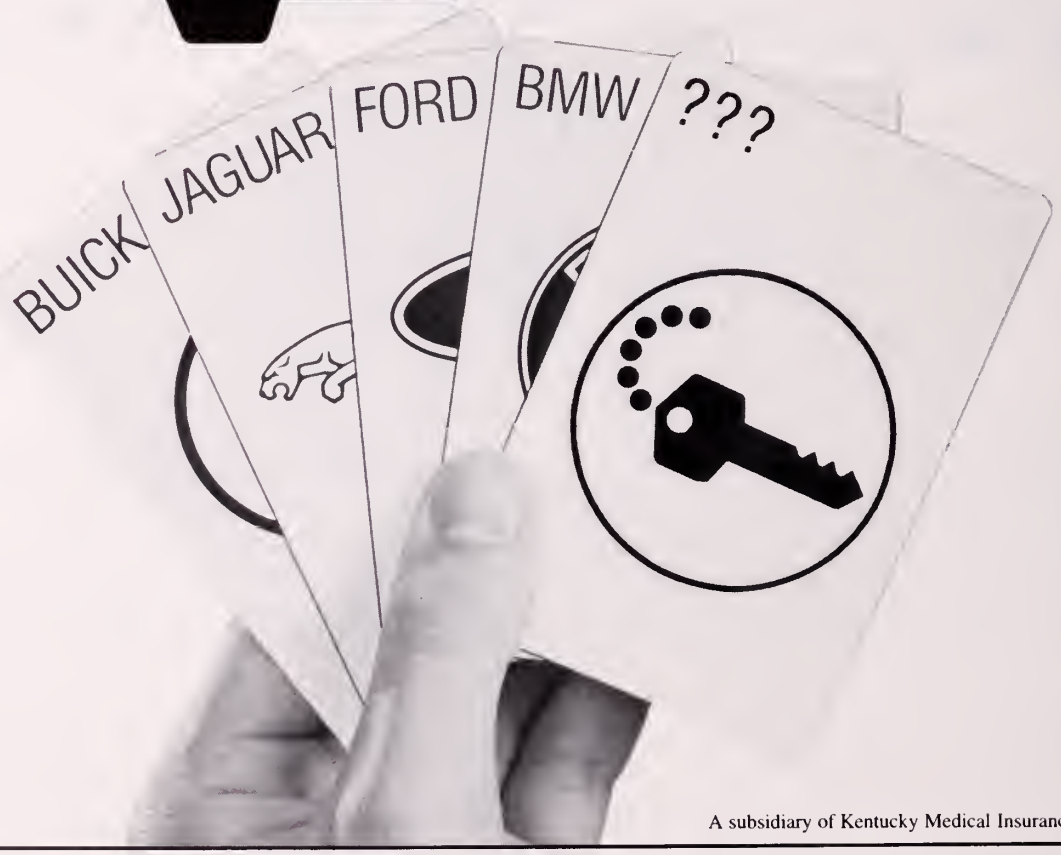
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Administer cautiously to allergic patients.
Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.
Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)
Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea), 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever), 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely.
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%; and, rarely, thrombocytopenia.

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The Surgical Treatment of Wolff-Parkinson-White Syndrome

From the Divisions of Thoracic Surgery and Cardiology, University of Louisville School of Medicine, Louisville, KY.
Reprint requests to Department of Surgery, University of Louisville, Louisville, KY 40292 (Dr Slater).

A. David Slater, MD
Joel Kupersmith, MD
Laman A. Gray, Jr, MD

More than 50 years ago, Wolff, Parkinson, and White described a clinical electrocardiographic entity in a series of healthy young patients consisting of attacks of paroxysmal tachycardia in the presence of an electrocardiogram showing a bundle branch block-like pattern with a short PR interval.[1,2] Isolated cases showing the same feature had been published earlier.[3-6] Subsequently, it became clear that some patients with this condition suffer from incapacitating or life-threatening arrhythmias.[7] With the advent of electrophysiologic studies and increasing understanding of cardiac conduction, it was demonstrated that the Wolff-Parkinson-White Syndrome (WPWS) was caused by a macro reentry phenomenon related to conduction through a normal atrioventricular (AV) node and an abnormal conduction pathway connecting the atrium and ventricle, the Kent bundle. In 1967, Durrer and Roos[8] used intraoperative epicardial mapping techniques to provide electrophysiology evidence of ventricular pre-excitation occurring via an accessory AV connection in a patient with WPWS.[9] Final demonstration of the presence of functional accessory AV connection and their importance in the genesis of WPWS occurred in 1968 when Sealy surgically cured a patient's arrhythmia with division of an accessory AV pathway.[10]

Case Summary

A 37-year-old male with a history of rheumatic fever in childhood, a cardiac murmur, and intravenous drug abuse had multiple admissions to his local hospital with palpitations, substernal chest pain, and shortness of breath. His electrocardiogram demonstrated tachycardia with a rate of 160-220 beats per minute with a wide QRS complex. He required multiple cardioversions for atrial fibrillation or flutter with rapid ventricular response and severe hypotension. He also had documented degeneration of the rhythm to ventricular tachycardia.

The electrocardiogram in Figure 1 demonstrated a short PR interval with a wide QRS complex with a delta wave, and the diagnosis of WPWS was made. An echo cardiogram showed concentric left ventricular hypertrophy and a thickening of the mitral valve. A cardiac catheterization with electrophysiologic evaluation revealed normal coronary arteries, mild mitral regurgitation, and a mitral valve gradient of 7-8 mm Hg. Programmed electrical stimulation demonstrated inducible tachycardia with evidence of pre-excitation through an accessory conduction pathway in the left ventricular free wall.

After failure of medical therapy with multiple agents, the patient agreed to surgery. Through a median sternotomy incision, intraoperative mapping, mitral commissurotomy, and division of a left ventricular free wall pathway were performed by an endocardial approach.

The patient has had no further tachycardia and has remained asymptomatic. His current electrocardiogram demonstrates a normal PR interval with absence of the delta wave.

Discussion

Patients with WPWS may present at any age beginning as early as several months of life. The majority of adults have otherwise normal hearts, although this syndrome may complicate a variety of acquired and congenital heart diseases, particularly Ebstein's anomaly.[11] Although many patients have electrocardiographic evidence of pre-excitation without symptoms, 80% of patients with WPWS and tachycardia have paroxysmal supraventricular tachycardia and 15% to 40% have atrial fibrillation or flutter.[12]

Patients with electrocardiographic evidence of WPWS, otherwise normal hearts and no tachycardia have normal life expectancy. In patients with WPWS and recurrent tachycardia, there is considerable morbidity, and sudden death occurs in a small proportion of patients. Sudden death is most common in patients with paroxysmal atrial flutter and fibrillation with rapid antegrade conduction across the accessory pathway causing rapid ventricular response occasionally degenerating to ventricular tachycardia or fibrillation.[2]

In the past, surgery was recommended only for patients with arrhythmias refractory to medical therapy or those patients with unacceptable side effects from medication. With improved techniques and results, surgery is now recommended for most patients with WPWS who have tachyarrhythmias. Surgery is particularly appropriate for young patients who would otherwise require a lifetime of medical therapy and for those patients who have WPWS and require other cardiac procedures.[12]

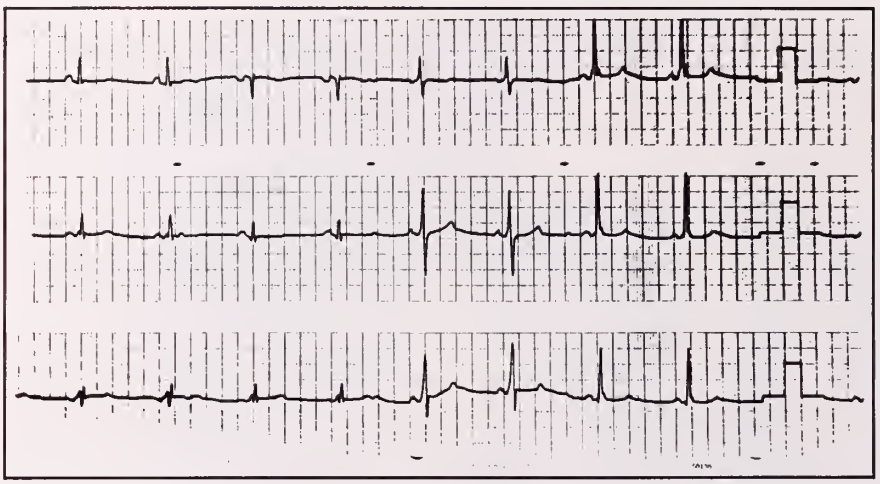


Fig 1. Twelve lead electrocardiogram with short PR interval and delta waves.

Accessory AV conduction pathways may be located at any point around the anulus of either AV value except in the fibrous junction of the aortic and mitral valves. Because of the importance of anatomic isolation for surgical treatment, conduction bundles are localized to one of the four following areas: left free wall, right free wall, anterior septal, or posterior septal (Fig 2). The position of the bundle is suggested by the electrocardiogram as either type A or B according to the orientation of the delta wave and the QRS complex in the precordial leads. Type A usually corresponds to left free wall and B to right free wall accessory bundles. Exact localization, however, requires positioning of multiple catheter electrodes preoperative in the electrophysiology laboratory. The presence and localization of accessory pathways are determined by atrial and ventricular pacing and by induction of supraventricular tachycardia.

The surgical procedure consists of two aspects: (1) intraoperative mapping to further localize the conduction bundle(s) and (2) division of the accessory pathway(s).

Mapping maneuvers require a coordinated effort between the surgeon and the electrophysiologist recording epicardial electrograms and their timing at various points around the AV junction.

If the patient is in normal sinus rhythm with stable antegrade pre-excitation, the initial mapping is performed using a ventricular reference. The mapping identifies the sight(s) of earliest activation located on the ventricular insertion of the accessory pathway. In patients in whom stable antegrade pre-excitation is not present, the atrium is paced near the suspected sight of the accessory pathway to elicit pre-excitation. If stable antegrade conduction cannot be elicited, the accessory pathway can be located by atrial mapping during reciprocating tachycardia or ventricular pacing.[12] Cardiopulmonary bypass may be necessary in patients with hemodynamic instability during pacing or tachycardia.

Because accessory bundles may be located anywhere in the tissue between the atrium and ventricle except in the valve anulus itself, the guiding principle in division of the accessory pathway is to dissect all the tissue in the atrioventricular groove at the sight of the conduction pathway. The initial surgeries for right free wall bundles were performed with an external dissection of the AV fat pad elevating the right coronary artery and the AV groove fat pad until ventricular muscle tissue was exposed.[13] This can be performed without the need for cardiopulmonary bypass; however, exposure of the pathways in the septal and left free wall is more difficult. Cardiopulmonary bypass is required, and the heart is opened to expose the appropriate atrial chamber. An endocardial incision is made in the atrial tissue approximately 2 mm from the anulus (Fig 3). The atrial wall is completely transsected, and dissection of the AV groove fat pad is performed along the ridge of ventricular muscle until the epicardial surface of the ventricle at the distal extent of the fat pad is reached. Care is taken to remain directly on the ventricular muscle ridge to avoid injury to the circumflex coronary artery. Accessory bundles in the posterior septal region are particularly difficult to divide because of proximity to the His bundle and because of difficulty in dissecting the pyramidal space between the epicardial surface and the junction of the mitral and the tricuspid anuli. An external approach with dissection of the AV groove directly beneath the coronary sinus has been described and is gaining in popularity.[14]

Following completion of the dissection, mapping maneuvers are repeated to insure division of the accessory bundle and for identification of possible multiple bundles.

Refinement in mapping and surgical procedures has led to success rates of almost 100% although some patients may require multiple procedures. This too is decreasing in frequency with greater appreciation of multiple pathways and experience, particularly in posterior septal dissections. The operative mortality is 1% to 2% and should approach 0% in patients with otherwise

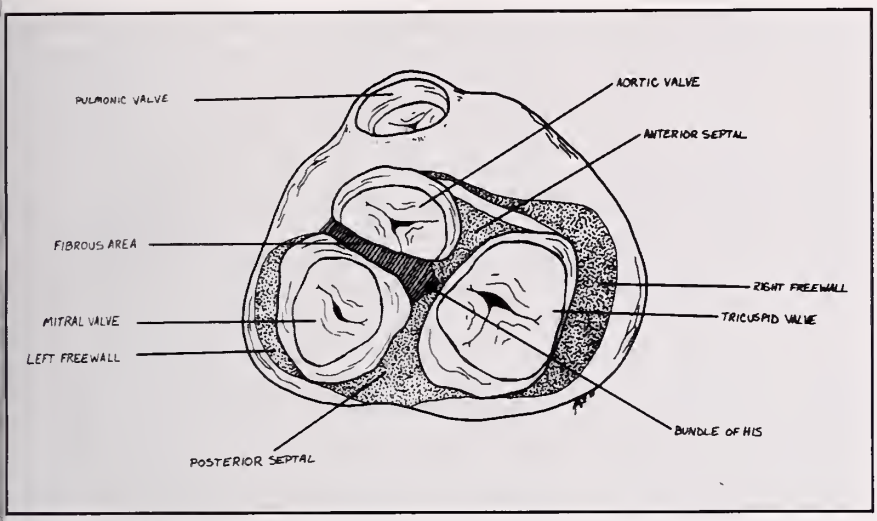


Fig 2. Cross section of heart.

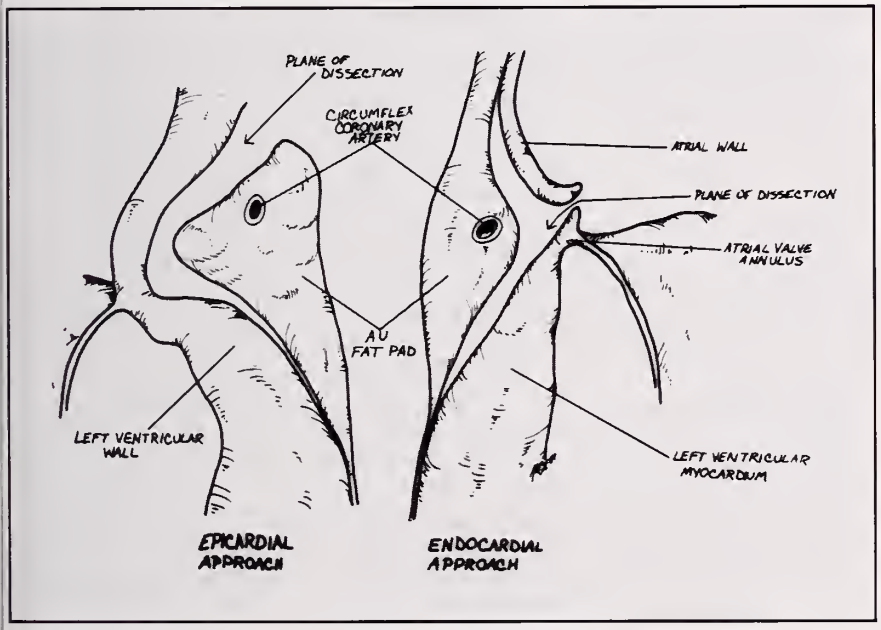


Fig 3. Epicardial and Endocardial dissection of AV groove.

normal hearts.[15] In conclusion, improved understanding of WPWS as well as experience and sophistication in techniques of evaluation and surgical technique have provided safe and permanent cure in patients surgically treated for WPWS.

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Subacute Encephalitis and the AIDS-Associated Organic Brain Syndrome

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The increasing prevalence of the acquired immune deficiency syndrome (AIDS) has been accompanied by the realization that victims may develop a subacute encephalitis, often culminating in dementia. Neuropsychiatric symptoms may be a striking component of the syndrome, and at times may represent the initial presentation of the illness. Mounting evidence supports the causative role of the Human Immunodeficiency Virus (HIV) in AIDS-associated subacute encephalitis. Patients with risk factors for the development of AIDS, who present with neuropsychiatric complaints, should not only be evaluated for remediable organic pathology, but also for HIV induced subacute encephalitis.

In a few short years AIDS has become widely recognized as a major public health concern. The syndrome of AIDS is defined by the Centers for Disease Control as the presence of a reliably diagnosed disease at least moderately predictive of an underlying cellular immunodeficiency.[1] Although there has been a virtual explosion of information in the medical literature concerning the virology, immunology, and pathology of AIDS, there has been relatively little written about the neuropsychiatric aspects of the disease. This is true even though it has been well documented that 30% to 40% of all AIDS patients develop neuropsychiatric complications.[2,3] Navia et al report a series in which 49% of patients developed severe dementia, while 16% manifested a moderate dementia.[4] The history of many patients with AIDS reveals that prior to developing symptoms of immunodeficiency the individuals suffered from withdrawal, apathy, lethargy, and other subtle psychiatric symptoms, suggesting that the patients may have exhibited the neuropsychiatric manifestations of the syndrome prior to experiencing any emotional repercussions from the diagnosis. It has recently become more widely accepted that the neuropsychiatric symptoms associated with AIDS are the result of the direct central nervous system (CNS) effects of the disease.

Not long after the first description of AIDS, neurologic complications were noted to be a common finding. Dementia, delirium, seizures, paraparesis, hemiparesis, incontinence, mutism, and coma are symptoms of various neurologic complications of AIDS. AIDS-related CNS pathology can be divided into several categories: infections; neoplasms; vascular complications; peripheral neuropathy; and other conditions. Within each category there are several specific etiologies (Table). Of the 50 patients with neurologic complications analyzed by Snider et al, 31 were found to have CNS infections, nine had neoplasms, six suffered from vascular complications, while eight were noted to have a peripheral neuropathy.[3] Subacute encephalitis was by far the single most common neurologic complication, with 18 diagnoses.

The psychiatric complications of AIDS have not been well defined but preliminary work suggests that they are pervasive clinical features in AIDS patients hospitalized during an acute illness.[5] Adjustment disorder, major depression, and organic brain syndrome are three of the most commonly made psychiatric diagnoses associated with AIDS.[1] Perry and Tross reviewed 52 patients and found that 82.7% had signs of mood disturbance and 65.4% had criteria for the diagnosis of organic mental syndrome.[5] Diagnosis of major depression in AIDS is complicated by the fact that symptoms often used to establish the diagnosis of depression can also be caused by the AIDS disease process. AIDS patients, even though not depressed, may exhibit ano-

TABLE
Neurologic Complications of the Acquired Immune Deficiency Syndrome (AIDS)

Neoplasms	Primary brain lymphoma
	Meningeal lymphoma
	Epidural malignancy (lymphoma, etc.)
Vascular Complications	Cerebral hemorrhage
	Thrombotic endocarditis (non-bacterial)
	Cerebral arteritis
Infections	Subacute encephalitis
	Toxoplasma gondii
	Atypical *Mycobacteria*
	Cryptococcal meningitis
	Progressive multifocal leukoencephalopathy
	Fungal infections
Other	Aseptic meningitis
	Polyneuropathy (vacuolar)
	Retinopathy
	Mass lesion of unknown etiology

Adapted from Snider.[3]

rexia, weight loss, insomnia, and chronic fatigue. Patients who have AIDS and organic brain syndromes may present with various mixtures of affective and delusional components, but most will progress to severe dementia. Dementia is one of the most common and most important complications of AIDS, and for some patients it can be the most grave aspect of their illness.[4,6] Evidence is currently beginning to mount that the subacute encephalitis that gives rise to this dementia is the result of direct infection of the brain by the HIV.

The AIDS-associated encephalitis is generally insidious in onset, is often the initial presentation of the disease[7] and follows a progressive course culminating in dementia.[1,6] Patients initially complain of lethargy, loss of interest in usual activities (including sex), malaise, fatigue, and dysphoric mood, suggestive of a mild chronic depression,[3,8,9] while others have presented with acute mania.[10] The mental status examination may be normal but commonly reflects subtle problems with concentration and memory. Patients may have difficulty remembering things such as telephone numbers and appointment times. Cognitive function declines in a global fashion, usually over a period of only months.[6] Navia and Price describe the hallmarks of AIDS dementia as psychomotor slowing and global cognitive impairment.[6] In their report of three patients, Kermani et al described the triad of mood disturbance, memory deficits and thought disorder.[11] During the early phases of the encephalitis, associated neurologic signs may include a loss of coordination and lower extremity weakness causing an unsteady gait. In a pre-terminal state the patient generally is disoriented, confused and possibly mute, with progression of neurologic signs to include increased weakness and ataxia, incontinence and, possibly, seizures.[1,6,9] Patients manifesting an acute psychosis characterized by hallucinations (especially visual), delusions (especially of a paranoid nature) and psychomotor agitation usually have another concurrent process such as an opportunistic infection or metabolic derangement. The end result remains a debilitating dementia.[8,12]

Patients that fall into a group at risk for the development of AIDS should undergo an organic workup with the initial presentation of psychiatric symptoms. An extensive search for remediable organic etiology of cognitive dysfunction should be sought and managed appropriately. Changes in the electroencephalogram are non-specific, consisting of simply mild slowing.[7,13] Computerized tomography is invaluable in the diagnosis of space-occupying lesions such as cerebral neoplasms (notable primary lymphoma) and abscesses. Patients with subacute encephalitis demonstrate only cortical atrophy with possible dilation of the ventricular system and the absence of enhancing lesions.[3,14] Although few in number, patients studied with magnetic resonance imaging show changes consistent with edema and inflammation[13] and diffuse white matter disease.[15,16] Once the absence of a space-occupying lesion has been demonstrated, lumbar puncture can be safely performed. The cerebrospinal fluid of subacute encephalitis patients generally reveals a slightly elevated protein with mild hypoglycorrhachia. While not consistent, a mild mononuclear pleocytosis may also be present. Of note is the absence of evidence for other infectious etiologies.[3,10,13,17] An AIDS patient manifesting dysfunction in the absence of demonstrable focal lesions at CT, with a normal CSF and without metabolic derangement, should be considered to have subacute encephalitis.[3]

While a positive serum assay for HIV antibody helps to support the diagnosis of AIDS-associated subacute encephalitis, the dementing process has been reported to occur in its absence.[18] Further, CNS disease has been demonstrated in the absence of immunodeficiency[19] and may present prior to diagnosing AIDS.[1]

At postmortem, up to 90% of brains from AIDS patients are abnormal;[20] brains from patients with AIDS-associated encephalitis demonstrate gross atrophy with meningeal fibrosis. Atrophy stems from a reduction in both white and gray matter with enlargement of the ventricles.[3,14] Lesions within the gray matter consisted of nodules of microglia varying in distribution but generally found in the cerebrum, cerebellum, brainstem and spinal cord.[3,7,13,21] Some authors also describe the occurrence of giant cells.[16,20-22] Of note, however, is the conspicuous absence of a lymphocytic infiltrate, either perivascular or parenchymal. Neilson et al described the end-stage findings of cerebral neuronal loss with diffuse astrocytosis and scarring of the cerebral cortex, basal ganglia and thalamus.[7] White matter changes consisted of focal demyelination and microglial nodule formation without axonal destruction.[3,7,13] Immunohistochemistry was negative for *Herpes simplex*; *Toxoplasma*, *Pneumocystis carinii* and

Mycobacterium were not seen. In the series reported by Snider et al[3] staining for cytomegalovirus (CMV) was inconclusive, while Neilson et al[7] reported immunoreactivity to CMV at the center of microglial nodules. These authors, however, were unable to culture CMV from the neural tissue. Vacuolar degeneration has been documented in the centrum semiovale[23] and the gray matter of the temporal lobe and amygdala.[24]

It is now generally accepted that HIV itself is the agent underlying AIDS-associated subacute encephalitis and the consequent dementia. Shaw et al detected the DNA of HIV in five of 15 brains from patients with AIDS encephalopathy using Southern blot analysis.[25] The authors were also able to demonstrate viral-specific RNA in four of these patients, indicating that the viral genome was active within these brains. Ho et al were able to isolate the retrovirus from the CSF and/or brain tissue of 73% (24/33) of AIDS patients demonstrating neurologic syndromes.[19] Of patients with dementia, 63% (10/16) had HIV cultured from brain and/or CSF, providing direct evidence for the virus as the etiologic agent. Further, the virus evokes an immune response within the blood brain barrier as evidenced by the presence of specific antibodies in the CSF of 96% (22/23) of patients with AIDS or AIDS-related complex both with and without neurologic complications.[26] The presence of oligoclonal IgG to HIV in these patients indicates that the virus can replicate within the brain. Transfer of HIV from the brain tissue of afflicted patients to uninfected peripheral mononuclear cells has also been demonstrated.[16,24,27] These data, taken in light of the neurologic sequelae of AIDS, confirm the ability of HIV to infect the CNS directly. Although the targeted cell population remains to be definitely identified, evidence currently implicates the monocyte-macrophage line.[15,16] After providing evidence that HIV is capable of establishing a productive infection within the brain's mononuclear cells, Gartner et al postulated a resultant reactive astrocytosis which disrupts cellular interactions and culminates in cognitive dysfunction.[16] Non-human investigational evidence also supports the etiologic role of HIV in AIDS-associated encephalitis.[6,28,29]

Patients infected with HIV who develop neuropsychiatric symptoms, other than an acute reaction to the diagnosis itself, manifest an organic mental syndrome.[30] When cognitive function declines to such a degree that social and occupational functioning are impaired, the diagnosis of dementia is applicable. While not uniformly present, a concurrent delirium may develop, especially under the stress of hospitalization.

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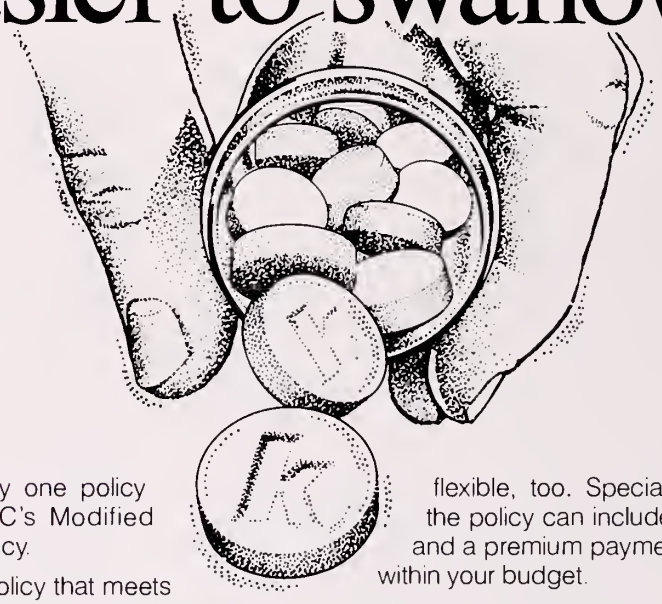
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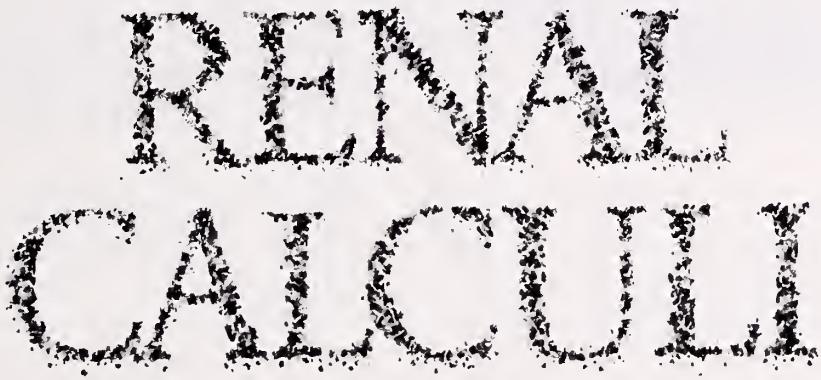
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Acute Intervention in Myocardial Infarction — Role of Thrombolytic Therapy and Adjuvant Angioplasty

Reprint requests to Cardiovascular Division, University of Louisville School of Medicine, 3rd Floor, ACB, 550 S Jackson St, Louisville, KY 40202 (Dr Joseph).

Abraham Joseph, MD
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The administration of thrombolytic therapy during the early hours of an acute myocardial infarction has been shown to improve residual left ventricular function and decrease mortality when compared to conventional therapy. Although reperfusion is successfully accomplished in up to 75% of occluded coronary arteries using tissue type plasminogen activator, this is often difficult to confirm using commonly accepted clinical predictors. Recent trials have demonstrated no advantage of immediate over delayed angioplasty in those who have successfully reperfused following thrombolytic therapy. The role of adjuvant angioplasty has therefore been confined to those with failed thrombolysis, or when recurrent ischemia due to rethrombosis following initially successful thrombolysis complicates the post-infarction course. The high incidence of reocclusion (30% to 33%) requires the availability of an experienced and available catheterization team and laboratory to intervene, if necessary, following the administration of thrombolytic agents.

Introduction

Early administration of intravenous thrombolytic therapy to patients with acute myocardial infarction has been shown to decrease mortality when compared to conventional treatment.[1] Streptokinase, over time, has a lower rate of coronary thrombolytic efficacy than recombinant tissue plasminogen activator. The ability to improve perfusion however is often accompanied by a residual high-grade stenosis that may create an unstable situation with the risk of reinfarction or recurrent angina. The potential usefulness of angioplasty as primary or adjunctive therapy in reducing the potential for reocclusion, lessening the residual stenosis, improving coronary blood flow, and thereby recovery of myocardial function, has been demonstrated in a number of previous reports.[2,3,4,5] The timing of angioplasty has been debated and a recent randomized trial[6] concluded that in patients with initial successful thrombolysis and suitable coronary anatomy, immediate angioplasty offers no clear advantage over delayed elective PTCA. The same study also noted that when thrombolytic therapy failed, immediate PTCA was attempted and successful in the majority of patients. The following case report illustrates the benefit of initial thrombolytic therapy and the occasional need for adjuvant mechanical intervention, angioplasty, to maintain vessel patency and myocardial function.

Case Report

HN is a 45-year-old white male who was brought to an outlying county hospital with symptoms of substernal chest pain of less than one hour's duration that radiated down both arms. The patient was mildly short of breath but displayed no clinical signs of heart failure. An electrocardiogram immediately on arrival (Fig 1) showed the patient to be in normal sinus rhythm with loss of R waves in the septal leads and extensive ST elevation in the anterolateral leads suggestive of an acute anterolateral myocardial infarction. The patient was begun on intravenous nitroglycerin, given an oral dose of Diltiazem and begun on thrombolytic therapy. He was given a 10 mg bolus of tissue plasminogen activator (tPA) and subsequently begun on an infusion to give him a total of 100 mg over the subsequent three hours. He was also simultaneously begun on a heparin infusion. The patient continued to have chest pain accompanied by persisting ST

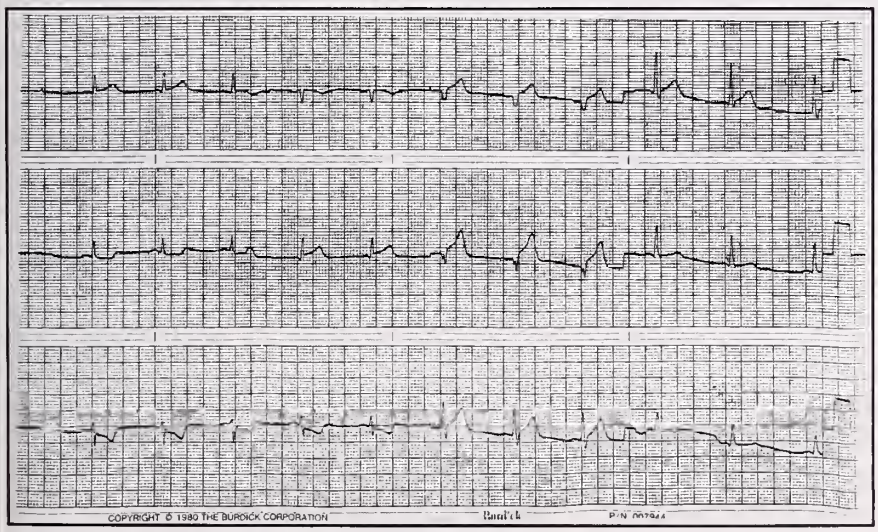


Fig 1. Electrocardiogram on arrival in the Emergency Room.

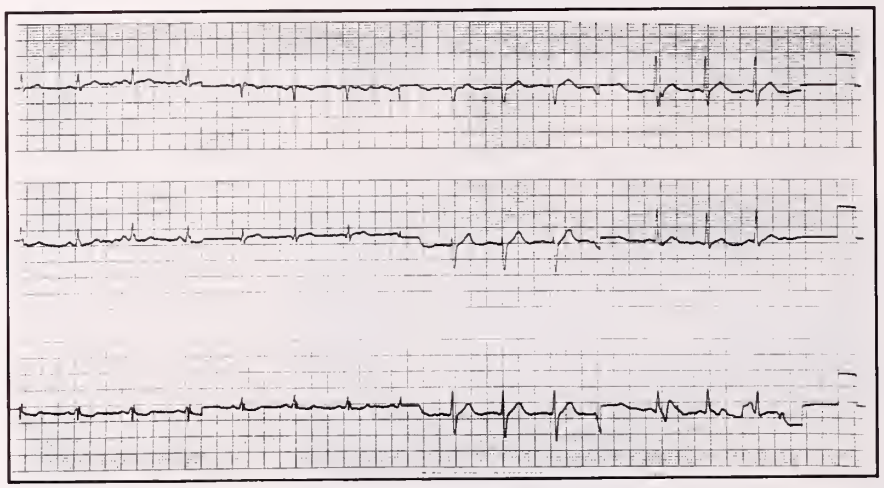


Fig 2. Electrocardiogram on arrival in the Catheterization Laboratory.



Fig 3. Coronary angiograms in the lateral view showing a high grade occlusion of the LAD following thrombolytic therapy.

segment changes in the same leads and the decision was made to transfer him by helicopter to Humana Hospital University of Louisville. He subsequently arrived at the Cardiac Catheterization Laboratory and an electrocardiogram done at 1:37 AM showed him to be in sinus rhythm with resolution of the ST segment abnormalities in the anterolateral leads (Fig 2). The patient still complained of mild retrosternal chest pain and on cardiac catheterization displayed evidence of mild anterolateral and apical hypokinesis on the ventriculogram. Coronary angiograms revealed a high grade occlusion in the proximal left anterior descending coronary artery with an area of narrowing of 80% that appeared to involve the origin of the diagonal branch (Fig 3). The left anterior descending coronary artery appeared to be occluded distally. The circumflex and the right coronary artery appeared to be free of significant disease. As the patient appeared to have recanalized with the tPA and was free of chest pain, it was decided to continue anticoagulation and proceed with elective angioplasty at a later date should the patient continue to remain stable and free of chest pain. Approximately two hours after the conclusion of the procedure, the patient began to complain of recurrent chest pain and a repeat electrocardiogram showed recurrence of widespread ST segment elevation in the anterolateral leads with reciprocal changes in the inferior leads (Fig 4). He was promptly taken to the Cardiac Catheterization Laboratory and displayed a total occlusion of the left anterior descending coronary artery at the site of the earlier narrowing (Fig 5). Emergency angioplasty was performed with excellent physiological and angiographic results and total resolution of the occlusion with preservation of the first diagonal branch (Figs 6,7,8).

A follow-up electrocardiogram demonstrated resolution of the ST segment abnormalities and, except for the presence of small Q waves in the high lateral leads, no loss of R waves to suggest an anterior infarction (Fig 9). The patient was maintained on intravenous heparin and intravenous nitroglycerin and remained stable with no further episodes of chest pain.

His peak CPK recorded was 1139 with a MB fraction consistent with myocardial injury. His chest X-ray showed no signs of pulmonary edema and he made an uneventful recovery.

Discussion

In an effort to decrease mortality from acute myocardial infarction, reperfusion to augment oxygen supply to the ischemic myocardium has received increased attention. Dewood and his colleagues[7] demonstrated that nearly 90% of patients studied within the first four hours had coronary thrombi, the frequency falling to 54% in those studied between 12-24 hours after the onset of symptoms. Timely reperfusion of an

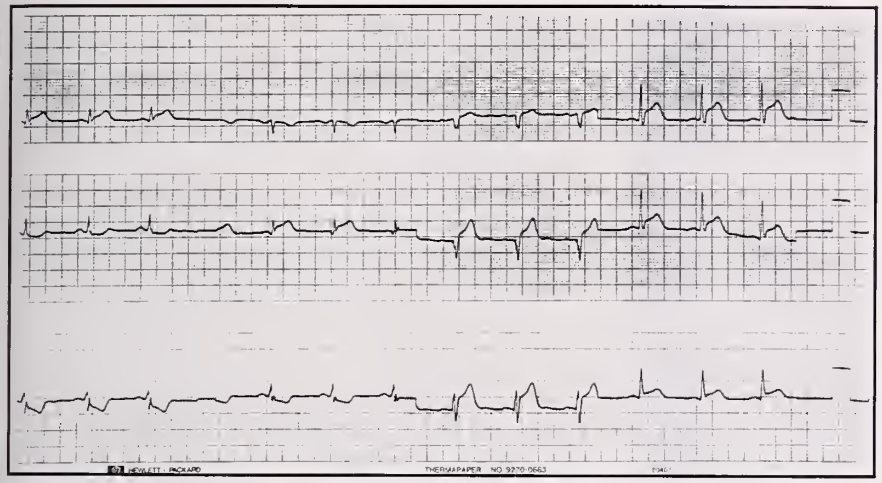


Fig 4. Electrocardiogram with recurrence of chest pain following completion of tPA infusion.

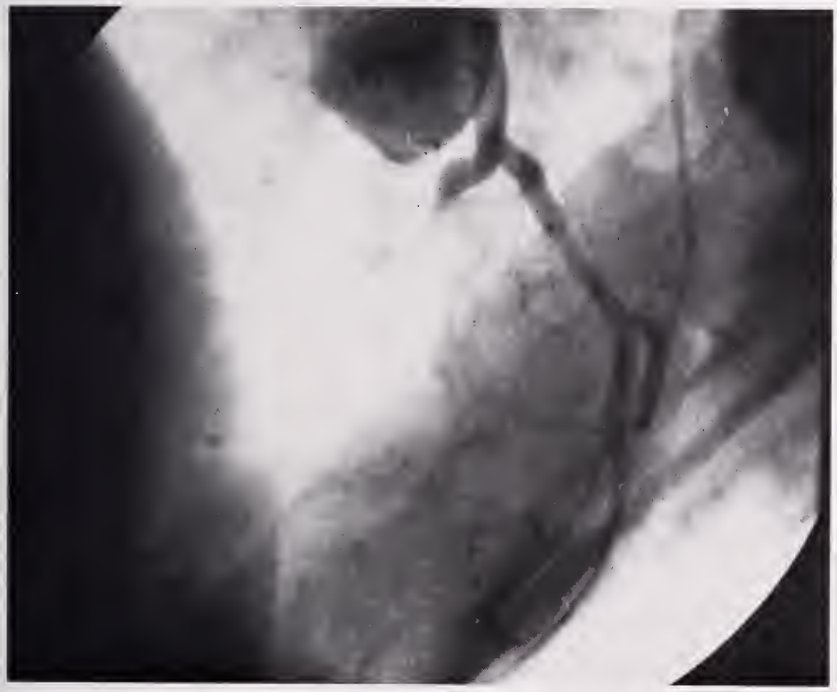


Fig 5. Coronary angiogram in the LAO cranial view now displaying total occlusion of the LAD.



Fig 6. Occlusion successfully crossed and artery recanalised with an 0.014" diameter flexible wire.



Fig 7. Successful recanalization of the LAD with preservation of the diagonal branches.



Fig 8. Coronary angiogram in the LAO cranial view displaying excellent angiographic results following successful angioplasty.

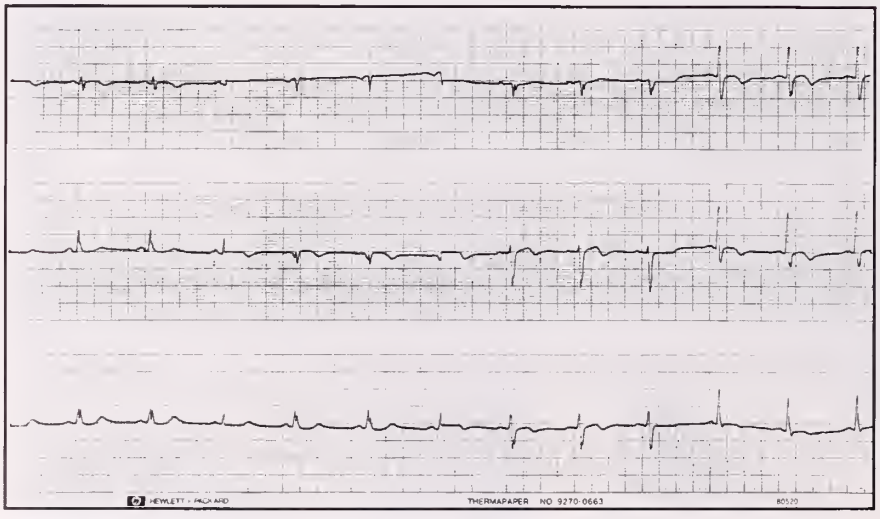


Fig 9. Follow-up electrocardiogram after successful angioplasty.

occluded artery in dogs will reduce infarct size.[8,9] In humans, due to the development of collaterals secondary to longstanding severe atherosclerotic narrowing, salvage of some myocardium by reperfusion may be possible for as long as 6-8 hours after the onset of the clinical features of acute myocardial infarction. Although spontaneous reperfusion has been shown to occur and limit myocardial damage,[10] it is unpredictable, prompting the need to use thrombolytic therapy to establish perfusion and salvage myocardium otherwise destined to undergo necrosis.

The popularity of thrombolytic therapy increased dramatically after angiographic demonstration of vascular reperfusion with the use of intracoronary streptokinase.[11] Many prospective and retrospective analyses have shown a striking difference in mortality in treated patients who had successful coronary artery perfusion (4% vs 15%).[12-15] The GISSI trial conducted in Italy[1] using 11,806 patients has shown a reduction in mortality of 18% at three weeks with more advantages the earlier treatment is begun and a maximum reduction of 47% if treated within one hour. Similar data either showing a trend towards a benefit in therapy, or a significant reduction in mortality, have been shown in other studies conducted around the world.[16-18] These observations emerged from studies using intravenous streptokinase, which, over time, has a lower rate of coronary thrombolytic efficacy than recombinant tissue type plasminogen activator.[19,20] However this improved ability to establish reperfusion also provides the potential for a higher frequency of recurrent ischemic events.[2] The inability to predict successful reperfusion using clinical or laboratory markers remains a continued problem, often necessitating coronary angiography in those with continued chest pain or large areas of viable myocardium at risk.

Immediate coronary angioplasty can be used to achieve reperfusion in myocardial infarction. One small prospective trial[24] comparing angioplasty with thrombolysis by streptokinase has shown both modes of therapy to be equally effective in achieving reperfusion with angioplasty producing significantly less residual stenosis and less exercise induced post-infarction ischemia. Angioplasty after thrombolysis can improve the recanalization rate,[3,21] and might diminish the incidence of in-hospital reocclusion, but this has not been proven.[22,5] Problems and potential disadvantages associated with acute angioplasty include the need to quickly initiate

attempts at reperfusion, the ready availability of an experienced catheterization team and laboratory facilities. Acute angioplasty may carry a higher risk with the potential for propagation of thrombus and occlusion of the vessel by dissection or spasm. Prospective studies using intravenous tissue plasminogen activator[6,23,24] have since shown no clear advantage of immediate angioplasty over delayed elective angioplasty in those with initially successful thrombolysis. Routine immediate angioplasty may be unnecessary in some patients who continue over time to display further dissolution of intraluminal thrombi after thrombolytic therapy.[3,25] Careful monitoring must continue after thrombolytic therapy for recurrent ischemia with early angiography and consideration for angioplasty should ischemia occur and the anatomy be suitable. The incidence of reocclusion has varied from 30%[2] to 33%,[26] prompting a crossover rate as high as 16% to an emergent procedure. In those with failed thrombolysis, immediate angioplasty has the potential of re-establishing patency in up to 94% of infarct related arteries without major additional risk.[6]

Conclusions drawn from published trials have so far convinced us of the need to administer thrombolytic therapy (tPA) within six hours of the onset of a myocardial infarction if no contraindications exist. It is our experience, too, that commonly used clinical markers of reperfusion, including relief of chest pain and electrocardiographic changes, do not reliably predict recanalization status and early angiography might identify patients who do not have reperfusion with intravenous tissue plasminogen activator or streptokinase, also detecting high risk anatomical features such as stenosis of the left main coronary artery or complex multivessel disease, despite limited availability and increased expense. With recent trials demonstrating no great benefit with immediate angioplasty in those with successful thrombolysis, as well as the frequent bleeding complications associated with acute angioplasty, and the observation that 14% of patients in the group undergoing elective angioplasty had further regression of an initially high grade lesion to a minor one, we reserve the procedure for those with unsuccessful thrombolysis or with existing contraindications to thrombolytic therapy. The case presented illustrates the efficacy of thrombolytic therapy in achieving initial patency of an occluded vessel and thereby salvaging myocardium during the first critical hours after an infarction, as well as the risk of reocclusion which would warrant more aggressive intervention. With a 30% possibility of reocclusion and a 25% incidence of recurrent ischemia prompting a crossover to an emergency procedure in 16% of patients, careful monitoring must be continued in the days following thrombolysis. This may best be performed in a center with the availability of a catheterization team and a complete catheterization facility to perform emergency angioplasty, or even make emergent bypass surgery available as an option.

The transfer by helicopter of these acutely ill patients to a tertiary care center in the hours following initiation of thrombolytic therapy has been proven safe and effective[27] in areas around the country. This will not only offer the patient the benefits of early initiation of thrombolytic therapy but also provide the opportunity for mechanical or surgical intervention should thrombolysis fail or recurrent ischemic events complicate the post-infarction course due to rethrombosis.

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A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

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Recommended dosage schedule

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Bone and Joint* Skin/Skin Structure*	Severe/Complicated	750 mg *B.I.D.*
Urinary Tract*	Mild/Moderate	250 mg *B.I.D.*
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Infectious Diarrhea*	Mild/Moderate/Severe	500 mg *B.I.D.*

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BRIEF SUMMARY
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INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below

Lower Respiratory Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Pseudomonas aeruginosa, Haemophilus influenzae, Haemophilus parainfluenzae,* and *Streptococcus pneumoniae*

Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro® may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General

As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions

Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients

Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility

Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E. coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C

Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

Nursing Mothers

It is not known whether ciprofloxacin is excreted in human milk, however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

GASTROINTESTINAL *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia.*

SKIN/HYPERSENSITIVITY *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum

SPECIAL SENSES *blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste.*

MUSCULOSKELETAL *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout

RENAL/UROGENITAL *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis

RESPIRATORY epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic – Elevations of ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%)

Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%)

Renal – Elevations of Serum creatinine (1.1%), BUN (0.9%)

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

Benefit for the Kentucky Society to Prevent Blindness

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The Louisville-based playwright, Vaughn McBride, has just completed a strongly moving drama of one woman's life given totally to the conquest of an infectious blinding disease — trachoma — in the mountains of Kentucky. Miss Linda Neville (1873-1961) of a prominent and wealthy Lexington family literally devoted her capital resources, her energies, her large family home, and her life as an agent to prevent blindness and improve related medical problems in eastern Kentucky. Her dedicated hand and heart were felt in Hindman, Hyden, Jackson, Liberty, Little, Oneida, Frenchburg, Buckhorn, Caney Creek, Cut-Shin Creek, Poor Creek, Greasy Creek and dozens of other small communities from 1908 to the early 1950s. She found the hearts of attractive but prematurely aging mountain mothers and lanky suspicious fathers. She secured mule-drawn jolt wagons where there were no roads, and passes on the L&N Railroad to bring trachomatous children to the best of medical care in Lexington and Louisville.

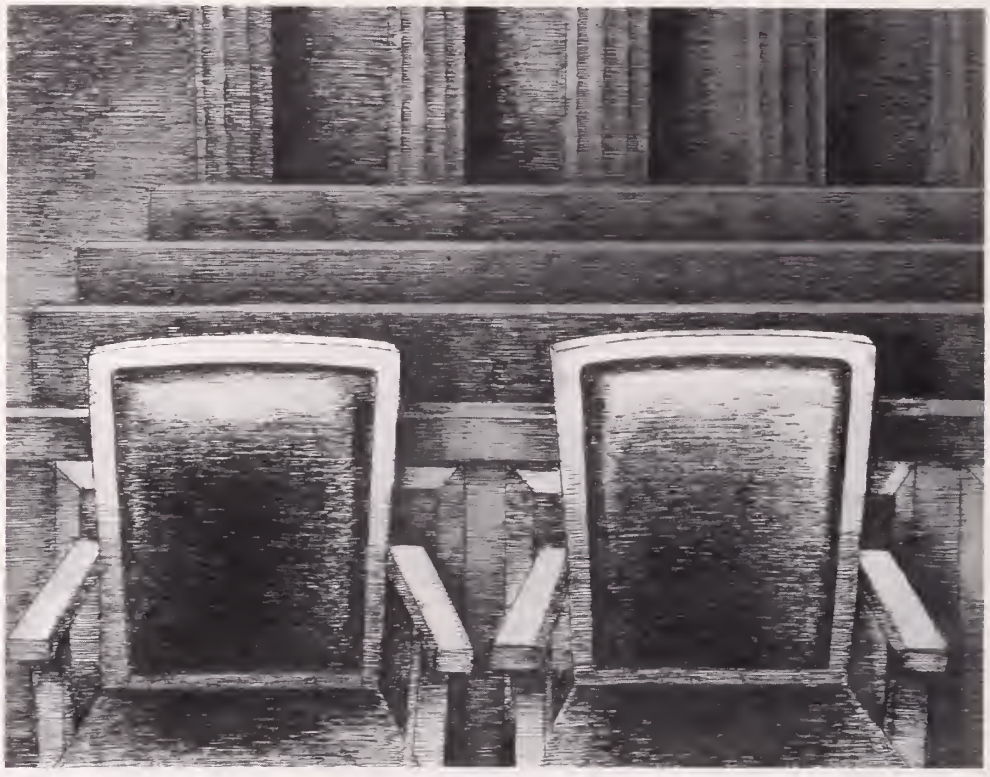
Without any fees involved she secured the service of a few dozen private practitioners in Lexington and Louisville, trebled the budget of the State Health Department in Frankfort, and brought in the uniformed U.S. Public Health Service of 19 physicians from Washington, D.C. She founded the Kentucky Society to Prevent Blindness in consort with creation of the National Society to Prevent Blindness in New York City. She removed fear and prejudice, as well as mountain bootleggers and urban shysters, from her route.

Medically it is rare for any disease to be totally eliminated. This has been done, however, with trachoma in the state of Kentucky. From the elite ivy towers of Bryn Mawr College in Philadelphia, to finishing experiences in Europe, and the gracious tables of the Idle Hour Country Club in Lexington, she donned men's boots and obtained the support to reach her goals.

Her targets were both individual patients (a *patient* by definition is one who suffers) and also the collective force that could be evolved from grossly limited state health programs. From a state of non-existence she created rural county programs and took her horseback nurses to the isolated homes where children hid under the beds in painful photophobia.

Her spell-binding story will be unveiled at Wyatt Hall of Bellarmine College in a benefit performance on Wednesday, October 26, at 8:00 PM. A cocktail reception will precede at 6:30 PM. Kentucky-born actress Sylvia Cardwell will portray Miss Linda. Subsequent opening performances are scheduled Saturday, October 29, in Owensboro; Wednesday, November 2, at Ashland Community College; Thursday, November 17, in Lexington at the Singletary Center for the Arts; and Thursday, November 10, at Market Home Theatre in Paducah. Start up costs have been underwritten by Blue Cross and Blue Shield of Kentucky. Tickets should be secured from the Kentucky Society to Prevent Blindness, 727 Starks Building, Louisville, phone 584-6127.





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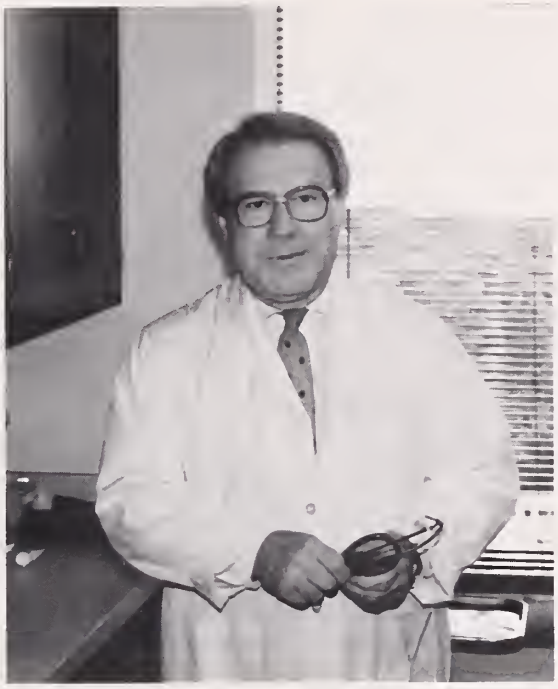
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KMA's 1988-89 Leader



Bob M. DeWeese, MD, cannot remember when he didn't want to be a doctor. Growing up in a small rural town in Ballard County, Kentucky, he was convinced at an early age how he wanted to spend his life. "It seems as far back as I can remember that's all I wanted to do. It's difficult to pinpoint any one thing that influenced me in the direction of medicine. Some of the people I knew and had the most respect for in my community were physicians. Also, I knew that I wanted to do more than finish high school and go to work. I learned early on that I didn't want to be putting up tobacco or putting hay in the barn on a hot day like today. My stepfather was a veterinarian and I would go with him on calls which greatly influenced my wanting to care for the ill."

After graduating from high school, Doctor DeWeese began his premed education at the University of Kentucky where he earned his baccalaureate degree in 1957, followed by a medical degree from the University of Louisville in 1961. He completed a general surgery residency at the University of Louisville Hospitals in 1966, and has been in the private practice of surgery since that time.

During these years he has had a broad involvement in organized medicine. He has held positions as president of the Jefferson County Medical Society and the Louisville Surgical Society. A Fellow of the American College of Surgeons and a Diplomate of the American Surgery Board, Doctor DeWeese is also a member of the AMA, Kentucky Surgical Society and Southeast Surgical Society. His involvement in KMA includes six years as Fifth District Trustee, Vice Chairman of the Board of Trustees in 1986-87, and service on numerous committees.

Issues and Concerns

Gesturing frequently as he speaks in a warm, direct manner, Doctor DeWeese fields all questions enthusiastically, projecting a feeling that everything about medicine is of urgent importance. His soft-spoken voice and low key demeanor belie the forthright and purposeful man who is going to be leading KMA in the coming year. He has a strong commitment to continuing the development of a solid, well-structured organization to be the voice for Kentucky's physicians.

While he has no specific project he plans to pursue, Doctor DeWeese has his priorities. "Personally, my main concern is what's going to happen to the practice of medicine as we know it and what's going to happen to the quality of care that we will or will not be able to give to our patients. We have been so distracted the past few years by all manner of economic turmoil and, while I think basically we must be dedicated to patient-oriented care, for the future of medicine the time has come when we as an organization have to speak out against those things which are adversely affecting our patients' freedom to choose their physician and facility and which tie our hands as far as the quality of care we give. No longer can we be deterred by outside forces that might prevent our delivering good medical care. These forces are based strictly on economic issues. Health care is costly no matter what you do. We've cut a lot of the fat out of the system, but the cost is not decreasing. We do about 55% to 60% of surgery on an outpatient basis in an effort to cut costs. What has happened is this has taken the patients out of the hospital so the hospital revenue has dropped. Consequently, outpatient care now costs as much as inpatient care. So, you see, everybody hasn't gone along with the inconveniences

and made the sacrifices that the patients have. Also, physicians today have more knowledge, ability to diagnose and treat, and procedures enabling them to help people live longer. High tech operations such as heart transplants, things we used to not be able to do, we can do now — but, they all cost. We must educate the public as to what is happening to them and to quality medical care.

"Physicians are a varied group, and they have the right to practice as they choose. If they want to practice within a planned care system, that's fine; if they want to practice independently, that's fine; it's up to each individual to decide. There will be alternate methods of health care delivery. That's fine, we don't have any problem with that. Patients get good care and the system works well with groups such as the Kaiser Foundation, and in many places that have closed panel HMOs or managed health care plans, but these people don't make $200 million a year out of the system.

"Organized medicine has to be flexible enough to work to inform people of what is going on no matter what their mode of practice. If the factors that control our destiny are greater than we are in changing them and we end up with a national health plan or all working in a for-profit company, then I think organized medicine will have to be prepared to go all the way to the other end of the spectrum and be a negotiating body for the physicians in order to maintain quality care for our patients."

The Legislature

Doctor DeWeese was very involved in Kentucky's Legislative Session this past winter and came away with a more positive impression of the General Assembly. "I enjoyed it. It was a learning experience. You encounter a lot of things that are encouraging, you also see a lot of things that are appalling to you. We had the opportunity to sit down and talk with the legislators about problems facing a lot of people — with the liability issue we have lots of allies. They began to listen to us and we feel if they know our interest and our concern is not self-serving and is for the betterment of all, then hopefully they will include us more in the committees and make an easier road for us. I came away knowing that if you want to get in the arena, if you want to fight, and if you want to do the things you have to do for your profession, you can get a piece of the action . . . but, you are playing in an "away court," and sometimes the "officials" are not your favorites. It's a process at which we are going to have to become more adept. If we can become allies of the public and they realize that when the KMA goes to Frankfort we are speaking for them and quality of care, and they understand and believe that, then they will have a tremendous influence on the legislature and make things easier for us in the future. I did learn that if you have a good issue that involves the people and you get enough people to educate and inform the legislators, and their constituents put pressure on them, you can get things changed."

With the signing of House Bill 551, 552, and House Concurrent Resolution 62 becoming law, KMA was very successful in its effort to enact significant Tort Reform in the recent legislative session. Doctor DeWeese was pleased. "I think everyone realizes we got more than we have gotten in a long time, but we didn't get all we wanted. Still, I feel reaction should be favorable to what was accomplished and there should be a feeling that the money spent on PLI was wisely spent and was very fruitful. There should be a willingness for us to keep the PLI campaign intact and to continue the efforts we have begun."

While the medical profession in Kentucky had tremendous support and representation in Frankfort from the physicians, their spouses and KMA Auxiliary members, a challenge for the new President is to see the KMA membership become a more active, involved group. The profession is not politically oriented, and Doctor DeWeese fully understands some of the reasons. "We all know there are those who prefer to be talkers and not doers. But I feel that basically the real reason is we *are* a profession and our educational process and entire professional lives have been directed toward being able to care for ill patients. We have been placed in this narrow spectrum, because it's what we want to do and what we do best. We don't really want to be impeded by operating a business in our office — we want to take care of our patients and help them to be healthy. It's difficult to go against our training and realize that we must get outside of

this environment in order to protect it. However, the threats to the way we practice are becoming so great that we have no choice. We really don't pay too much attention to what happens to the other fellow, but when it starts hitting everyone, then suddenly we have a problem. More and more people are now aware of these problems and are willing to become involved. It will take the efforts of a lot of people, but as we strengthen our position in Frankfort more physicians will realize the value of becoming involved.

"The Kentucky Physicians Care Committee has done a lot of the groundwork for us in Frankfort. They were there last year to present documentation of how we are providing health care for the indigent. They presented our concern that currently this care is primarily the financial responsibility of the state's physicians, even though it is really a societal problem. Well, the legislators began to listen, and while indigent care did not get that much attention in the legislative session itself, we were invited to testify during the interim session, in the committees and so forth. We feel we have received a lot of credibility because of this program. I hope we will continue it — we have to take care of these people."

AIDS

Much has been accomplished by the KMA in an effort to educate and assist Kentucky physicians in dealing with AIDS. Doctor DeWeese has some very definite thoughts on this devastating disease and the attention it requires. "I don't think we are so naive as to feel that we are going to morally cleanse the population, so we have to take the second best shot and that is to educate at all age levels, beginning during the school years. Unfortunately, there are a great number of people who are beyond the school years who still do not know anything about sex education. Somewhere along the way we may have to favor stricter testing guidelines and other methods of decreasing the exposure. Based on our knowledge of the disease and our current predictions, the things we are doing are probably adequate. However, if we've missed the mark and this turns out to be another bubonic plague episode, then we've not done the right thing."



KMA Membership

A person who is involved in numerous organizations, Doctor DeWeese feels it is better to be on the inside than the outside when trying to be heard. "It's our professional organization, one which tries to embody and carry out the wishes of its membership. It is the instrument through which the members can be heard and it reflects the thoughts and wishes of the majority of its members. KMA through the years has represented its members in all the problems they face in practicing medicine. It is an ever changing picture — and that is the way it should be — whatever the crisis is in organized medicine, KMA is there trying to solve it."

Doctor DeWeese is very candid in his remarks concerning the influences that led to his interest in KMA leadership. "At first you are naive and think 'Gosh, I can sure do a better job than anybody else,' — and then suddenly you realize what a great job everybody else has done through the years. That's part of the educational and learning process — finding out what's really going on. I have always liked politics, but beyond that I have personally felt that leadership was an area where I could possibly make a difference as far as the future of medicine goes and in helping people understand what we are all about and taking what we have and salvaging the best part of it for the future."

In considering the future, Doctor DeWeese feels a need for more involvement

in organized medicine by the medical students and the young physicians just beginning practice. They need the encouragement of a more positive image of their profession. "I think we must be honest with the young people going into medicine and tell them it is never going to be the way it was. There are so many factors we no longer control. But if they go into medicine for the right reason, for the art of healing, then it can be just as rewarding as ever. More so, because of technological advancements and scientific knowledge. The challenges are exciting and greater than ever before, and the demand for good physicians will continue to be just as great as it has been."

Doctor DeWeese is challenged, dedicated and deliberate in his outlook for the future of KMA. "Our overall goal and number one priority here has always been a guaranteed quality medicine and availability of medicine for everyone regardless of ability to pay. That is what we've striven to do through the years, and will continue to do. Hopefully, we can influence the legislature to pass the proper legislation for Medicaid and indigent care funding, and if we can that would be tremendous. We also have an obligation to monitor our medical schools to ensure that the quality of teaching is what it should be and that students being turned out are the caliber that should be entering the practice of medicine.



We must continue to be the leader and spokesman for physicians on issues such as AIDS and quality of care. I believe we will have more success in the next legislative session with our PLI policies and programs. There are numerous issues we are working with, many things we do which do a lot of good but do not get much publicity because there are those who don't toot their own horn. A strong organization can deal with whatever problems arise, and KMA is a strong organization."

Family and Relaxation

Doctor DeWeese and his wife, Angela, have three sons and one daughter. The eldest, John, is married and a marketing executive with a hospital supply company. As a senior at the University of Louisville School of Medicine, son Craig is following in his dad's footsteps. Their only daughter, Amy, a senior at the University of Kentucky, is joined on campus by their youngest son, Steve, a junior. Doctor DeWeese is very much a family man. "I have a wonderful family. My wife and I share the philosophy that while the children are around we will spend as much time with them and do as much as we can with them and it will pay off. So far, it has paid off." He and his three sons make a compatible foursome so they relax together on the golf course. Amy enjoys challenging him on the tennis courts. His hobby is gardening. "I can go out into my garden for two hours and if the beeper doesn't go off, I might as well be in Africa as far as relaxing and getting away from it all. I take pride in gardening. You can see the fruits of your labor very quickly, and a little tender care on plants is quite rewarding."

Doctor DeWeese feels the fruits of his labor as President of KMA will be rewarding if he can reflect on the year and say, "We improved the image of organized medicine. Now, more than ever, when we go before government groups or wherever to represent medicine, everyone knows we are speaking because of genuine concern for the welfare of our patients and the people. I think if we can foster and improve this image, which has already taken roots, I will certainly feel the year was a success."

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References:

1. A. Morales et al., New England Journal of Medicine: 1221. November 12, 1981.
2. Goodman, Gilman — The Pharmacological basis of Therapeutics 6th ed., p. 176-188. McMillan December Rev. 1/85.
3. Weekly Urological Clinical letter, 27:2, July 4, 1983.
4. A. Morales et al., The Journal of Urology 128: 45-47, 1982.

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FROM THE EDITORS

Medical waste washing up on the eastern shores dramatically demonstrates a new and ever deteriorating problem we face in the medical world. It is insufficient to transfer the responsibility to the municipalities. Our waste products are more complicated to destroy and can be more heinous if abandoned.

Medical waste is produced from everything we do. More needles, gloves, syringes, sponges, etc, are being used with the AIDS epidemic and more careful prophylaxis is being practiced. Many procedures and some therapies utilize nuclear substances which take special precautions not only to use, but need particular methods to destroy. Chemicals are always entering the medical world in the form of drugs, solvents, and laboratory substances. Laser creates gaseous refuse, the nature of which is derived from both tissue and the chemical breakdown from this energy source.

Buildings to house the expanding medical community require not only standard utilities, but also abundant air conditioning systems, sewage disposal and space for the exhaust from all the increased traffic.

No longer can we invent new technology without considering the impact on the environment and how to deal with the consequences of their use. Governments enact legislation germane to this area, but the rapidly expanding technological world outpaces the applicability of regulation.

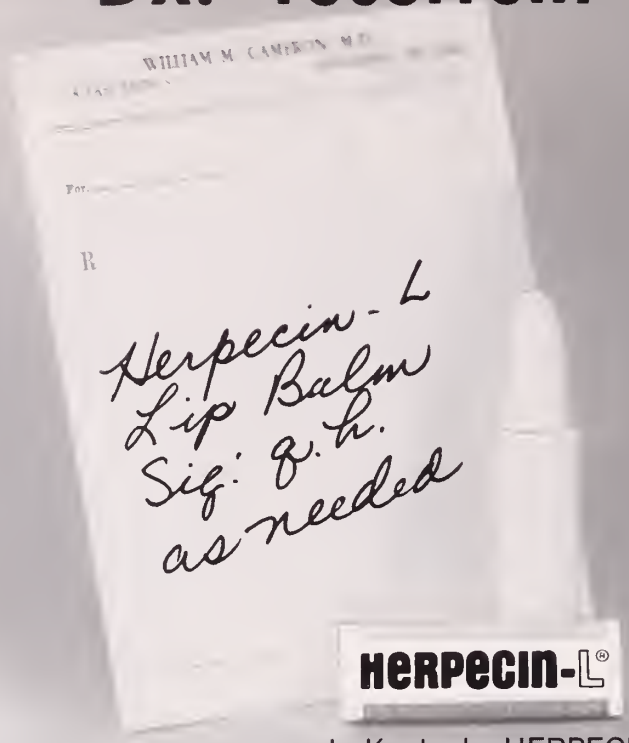
Physicians have a unique role in realizing a solution. Our perspective is obtained from scientific education, understanding of human medicine and the relationship to the community we have heretofore been accorded.

Let us take the leadership role. Respect the consequences of our own actions by being particularly careful with medical waste. Be active in the hospital or medical building management, watching what becomes of the debris and assuring its legitimate elimination. We should select only those technologies for which we can account a life history, from discovery to application to final destruction.

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Stephen Z. Smith, MD

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Confluence — An AMA Auxiliary Benefit

Since the AMA Auxiliary began sponsoring Leadership Confluences for county presidents-elect, more and more leaders have received top quality training.

This year leaders from seven Kentucky counties will travel to Chicago for this program. They will take advantage of the opportunities offered at this meeting to meet county presidents-elect from other states and to share some of their ideas and concerns. They will also gain ideas and programs from the other participants that might be just what their county auxiliary needs.

The purpose of the meeting is to offer leadership training and program information to county auxiliary leaders. Subjects covered are diverse: Effective Programming for Quality Meetings; Every Member — A Vital Member; Team Efforts — Medical Societies and Auxiliaries; Providing Support Systems for Members' Needs. Doctor James E. Davis, President of the AMA, will address the Confluence as well as Katherine H. Chavigny, PhD, who will speak on "The Nursing Shortage."

Breakout sessions will offer subjects on The Health of Adolescents; Aids Education for Youth; Teen Suicide Prevention; Intergenerational Programming for Older Americans; How to Run a Meeting; and Writing is Right.

Participants return home with a new enthusiasm for auxiliary involvement and committment. Confluence attendees share the new knowledge with not only their county auxiliary but many times continue on to provide leadership for the state organization. I will always remember attending Confluence as a county president-elect. I realized the potential of the medical auxiliary and made my committment to it.

Carol Franks
AKMA President



Left to right: Mrs. Anne Nichol, Mrs. Pam Potter, Mrs. Carol Franks, Mrs. Esther Jansing, Mrs. Debbie Hayden and Mrs. Juliette Grumley.

Digest of Proceedings August Board Meeting

The KMA Board of Trustees held its fourth meeting of the Associational year on August 10-11, 1988, at the KMA Headquarters Office in Louisville. Reports were given by the President, Secretary-Treasurer, Auxiliary President, and Senior Delegate to the AMA, who highlighted actions of the June AMA Annual Meeting. The Secretary of the Board of Medical Licensure summarized activities of that Board for the past year, and the Commissioner for Health Services discussed cuts in the state budget that would affect medical care in Kentucky.

The Board voted approval of the use of funds from the Legal Trust Fund for expenses incurred in a suit regarding confidentiality of peer review, and authorized a $10 voluntary billing for the Fund for 1989. Reports were accepted regarding a number of KMA committees, with details given on specific activities of the Committee on State Legislative Activities, and the Committee on Maternal and Child Health dealing with sex education in schools. Wally O. Montgomery, MD, Chairman of the Ad Hoc Committee on Professional Liability Insurance, gave a report to include the proposed PLI Campaign Plan 1988-1990, and the Board recommended its adoption to the House.

Nominations were made for a physician appointment to the Board of Medical Licensure to be made by the Governor, and an appointment was made to the KEMPAC Board.

The Board discussed Annual Meeting matters, and directed that Resolutions be drafted on the subjects of nursing education, medical services offered by hospitals, and minimal standards of care provided by health care plans. A listing of actions taken by the 1987 House of Delegates was distributed for review of the implementation of each action, noting the same information would be sent to every Delegate as a part of the Board Chairman's Report.

Russell M. Travis, MD, gave an update on the Kentucky Physicians Care Program. He provided a breakdown of participation by Trustee Districts. Doctor Travis also presented a proposal for a new program for voluntary assignment of Medicare claims as requested previously by the Board of Trustees. The Board approved the proposal for submission to the House of Delegates.

The Board finalized its six ad hoc committee reports, and reviewed the Reports of all KMA committees with recommendations to the House of Delegates for specific action on several Reports. The next meeting of the Board was scheduled for September 25, 1988.



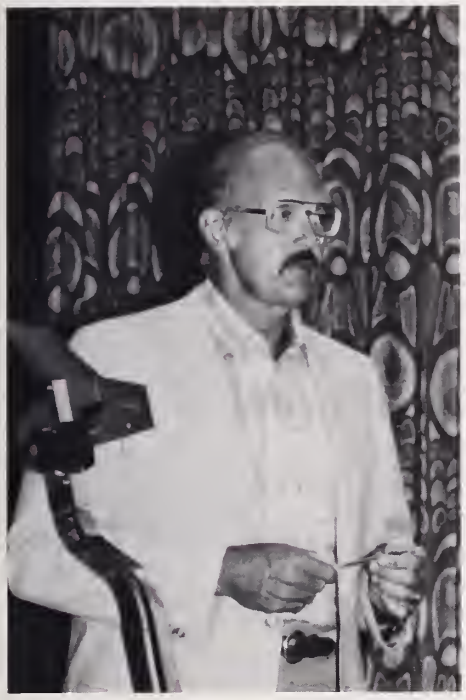
Board of Trustees with Chairman William B. Monnig, MD, presiding.



Wally O. Montgomery, MD, Chairman of the Ad Hoc Committee on PLI.



Fred C. Rainey, MD, Senior Delegate to the AMA.



Chairman of the Kentucky Physicians Care Operating Committee, Russell L. Travis, MD.



The KMA Auxiliary report was presented by President Carol Franks.



KMA was awarded a plaque as the top state in its category for the number of new members recruited in the AMA Young Physicians Section Outreach Program. President Barton, right, accepted the award for KMA from Donald J. Swikert, MD, Florence, who has served as a Kentucky Delegate to the AMA-YPS.



KMA President Donald C. Barton, MD, (L) and Vice-President Nelson B. Rue, MD, study the committee reports.



Secretary-Treasurer S. Randolph Scheen, MD, presented the Headquarters Office Report.

AMA Annual Meeting

KMA Officers attending the AMA Annual Meeting in Chicago, June 26-30, were faced with a lengthy agenda and numerous issues to consider. Actions taken by the AMA House included:

- Approving a report from the AMA Board of Trustees proposing a pilot program to create a Registered Care Technologist (RCT) in response to the severe shortage of nurses. The RCT report is a controversial issue in the nursing profession and several nursing organization representatives spoke during the reference committee hearing. The House amended the report to require certification and registration of the RCTs rather than licensure and referred the material to the Board for action.

- Approving a major report calling for significant reform in the Medicaid program that would create basic national eligibility and benefits standards; eliminate existing categorical requirements; and create adequate payment schedules. In a related action, the House referred a Resolution for action that calls on the AMA to establish a high priority task force to address the problem of indigent health care.

- Submitting a major initiative on drug abuse in the U.S. calling drug abuse the common element in America's most pressing social problems. The report contained recommendations that call for a redirection away from interdiction of illegal supply and a new focus on curbing demand through education and treatment.

- Adopting a policy calling on the AMA to sponsor or support legislation which would require employers currently required to offer participation in HMO's to provide employees with a choice of health insurance types whereby employees have free choice of physicians and health care facilities.

- Adopting a policy which asks the AMA to seek to have the federal government fund an independent study to examine and assess the present impact on the quality of medical care from mandated utilization review, medical necessity standards, methods of reimbursement, denial of hospital admissions for illness, and surgical and invasive procedures.

- Adopting a report recommending that a full evaluation of the resource-based relative value scale for physician services be completed before implementation decisions are made and that a reasonable transition period be included before any adoption of a Medicare fee schedule. National specialty societies will be convened by the AMA Board before testifying at the Physician Payment Review Commission hearings on the RVS in October.

KMA Delegates attending the meeting were:
Fred C. Rainey, MD, Elizabethtown
Donald C. Barton, MD, Corbin
Kenneth P. Crawford, MD, Louisville

Alternate Delegates:
Wally O. Montgomery, MD, Paducah
Robert R. Goodin, MD, Louisville
Harold L. Bushey, MD, Barbourville
Carl C. Cooper, Jr, MD, Bedford

Other Guests:
Bob M. DeWeese, MD, KMA President-Elect, Louisville
William B. Monnig, MD, Chairman, KMA Board of Trustees and HMSS Delegate, Edgewood
Hoyt D. Gardner, MD, AMA/KMA Past President, Louisville

Other Delegates and Alternates:
Young Physicians Section
Judith Joyce, MD, Delegate, Lexington
Donald Swikert, MD, Alternate, Florence
Resident Physicians Section
Warren Cox, IV, MD, Delegate, Louisville
Medical Student Section
Paul Austin, UK Delegate
Baretta Casey, UK Alternate
Todd Pesavento, UL Alternate
Terry Cleaver, UL Alternate

kma



Alternate Delegates Harold L. Bushey, MD, Barbourville (L), and Wally O. Montgomery, Paducah.



Delegates Fred C. Rainey, MD, Elizabethtown (L), and Donald C. Barton, MD, Corbin.



Bob M. DeWeese, MD, KMA President-Elect, Louisville (L), is seated with Alternate Delegate Robert R. Goodin, MD, Louisville.



Lelan K. Woodmansee, Executive Director of the Jefferson County Medical Society (L), is joined by Kenneth Peter, MD, President-Elect of the Society.

KMA Hospital Medical Staff Section Holds Annual Meeting

The KMA Hospital Medical Staff Section held its Fourth Annual Meeting at the KMA Headquarters Office in Louisville on June 16, 1988. KMA President Donald C. Barton, MD, Corbin, welcomed participants to the meeting and spoke of the importance of the KMA-HMSS in fostering cooperation and providing a conduit for discussion of mutual problems among the hospital, the medical staff, and the profession.

Rufus K. Broadaway, MD, of Miami, Florida, a member of the AMA Board of Trustees, spoke on the importance of quality assurance and AMA's role in that endeavor. AMA recently established an Office of Quality Assurance to foster quality measurement, evaluation, and assurance.

Russell L. Travis, MD, Lexington, presented information on relative value scales and his experience with the Resource-based Relative Value Scale (RB-RVS) study for physician services mandated by Congress and being conducted by Harvard University's School of Public Health. Doctor Travis is a KMA Delegate to the AMA and Chairman of the Kentucky Physicians Care Operating Committee.

Ardis D. Hoven, MD, Lexington, who served as Chairman of the 1986-87 KMA Ad Hoc Committee on the Development of AIDS Guidelines, presented medical facts and documented epidemiologic statistics on AIDS, the threat it poses to our population, and the growing concern of the state's citizenry with the spread of this fatal disease.

The major thrust of KMA during the 1988 Kentucky General Assembly was the passage of legislation to relieve the professional liability insurance crisis. Wally O. Montgomery, MD, Paducah, Chairman of KMA's Committee on State Legislative Activities and Ad Hoc Committee on Professional Liability Insurance, presented information on the passage of legislation to deal with PLI, as well as a comprehensive report on health and medical issues dealt with by the Legislature and followed by KMA. Doctor Montgomery noted that KMA enjoyed an extremely successful Legislative Session.

Burns M. Brady, MD, Louisville, a member of the KMA Committee on Impaired Physicians, spoke of the Committee's work in helping physicians who have become impaired by alcohol or drug dependency. He explained the steps members of the Committee take in helping to rehabilitate a physician and working with the families in the "healing process."

A recap of this year's activities of the HMSS Steering Committee was provided by Chairman William B. Monnig, MD, Erlanger. The Committee implemented resolutions dealing with smoking in hospitals and hospital security which were referred to the HMSS from the 1987 House of



1988-89 HMSS Steering Committee Members from left to right: Donald J. Swikert, MD, Chairman; James G. Kuhns, MD, Member at Large; Harold L. Bushey, MD, Alternate Delegate; R.J. Phillips, MD, Member at Large. (Vice Chairman Earl P. Oliver, MD; Secretary Roderick H. MacGregor, MD; and Delegate David R. Watkins, MD, were unavailable for photo).

Delegates. The Steering Committee also made recommendations to the Board of Trustees regarding "Inappropriate Requirements for Hospital Membership," as they relate to liability insurance.

Elections were held during the June 16 meeting for positions on the HMSS Steering Committee for the 1988-89 Associational year. Elected to these positions were:

Chairman:
Donald J. Swikert, MD, Florence
Vice Chairman:
Earl P. Oliver, MD, Scottsville
Secretary:
Roderick H. MacGregor, MD, Bedford
Delegate:
David R. Watkins, MD, Louisville
Alternate Delegate:
Harold L. Bushey, MD, Barbourville
Members at Large:
R.J. Phillips, Jr., MD, Owensboro
James G. Kuhns, MD, Louisville









Pictured clockwise from upper right: Burns M. Brady, MD, Louisville; William B. Monnig, MD, Erlanger, Chairman of HMSS since its inception in 1984; Rufus K. Broadaway, MD, Miami; and Ardis D. Hoven, MD, Lexington.

Updates

SMJAB Appoints Doctor Overstreet to Board

A. Evan Overstreet, MD, Editor of the *Journal,* has been appointed to the Board of Directors of the State Medical Journal Advertising Bureau, Inc. to serve for a period of three years.

KMIC Elects Richard F. Hench, MD, to Board of Directors

Kentucky Medical Insurance Company's directors unanimously elected former KMA president, Richard F. Hench, MD, to the Company's board of directors. Doctor Hench fills a position vacated by David A. Hull, MD, a Lexington general surgeon who resigned from the board upon retirement.

Former KMA Auxiliary President Appointed to the National Board of the American Cancer Society

Mrs. John D. (Phyllis) Cronin, a past president of the Auxiliary to the KMA, has been appointed Lay Delegate from the Kentucky Division to the American Cancer Society National House of Delegates. Mrs. Cronin works extensively with the ACS at both the state and national levels.

KMA Member . . .
Auxilian . . .

Our readers are interested in the important events occurring professionally in the lives of their fellow members. Do you, or someone you know, have a newsworthy note to submit for possible publication in your *Journal of the KMA*?

If so, please submit in writing to:

KMA Journal
3532 Ephraim McDowell Drive
Louisville, KY 40205

Complaints About Fees and Costs For Medical Records and Depositions

In recent months the Physician-Attorney Liaison Committee of the Kentucky Medical Association and Kentucky Bar Association has received complaints about several different types of "overcharges" or excessive fees for copies of medical records, for medical reports, and for depositions or courtroom testimony. Although some attorneys say that the problem is becoming more widespread and more serious, the Committee believes that a large percentage of the disputes or potential disputes are resolved by frank and open discussion between the lawyers and physicians involved and never come to the attention of the Committee. Because of the reported increase in frequency and severity of the complaints, however, the Committee members believe that *both* professions need to be reminded of some fundamentals of the Interprofessional Code of the Kentucky Medical Association and Kentucky Bar Association and of the respect and fair treatment owed by members of *each* profession to the other.

Code Provision

VI. COMPENSATION FOR MEDICAL REPORTS, DEPOSITIONS, COURT APPEARANCES AND OTHER SERVICES.

It is impractical to establish precise rules governing physician's fees for medical reports, reviewing medical records, conferences, opinions, depositions, court appearances, copies of medical records and other services. *It is important, however, that fees be reasonable and that they be discussed in advance by the physician and the attorney.* (Emphasis by authors.) In this way, the major cause of misunderstanding and dissatisfaction will be eliminated. Generally, the attorney who requests these services of a physician is primarily responsible for prompt payment of the physician's reasonable fees. Under no circumstances may a physician charge a fee for such services which is contingent upon the result of the lawsuit.

Discussion

1. *Copies of Medical Records.* Several complaints have involved costs charged or sought to be charged by the physician's office staff for simply making photocopies of office records. The committee recognizes that several different approaches can be made to defining a "reasonable" charge for copies of medical records; the physician's office staff, however, should recognize the difference between the clerical act of photocopying medical records and the physician's preparation of a medical report based on those records. As the Code states, "it is impractical to establish precise rules governing fees for . . . copies of medical records." Upon a complaint reciting specific dates, persons and circumstances, however, the committee will look very closely at the reasonableness of a charge for simply making photocopies or existing records.

2. *Medical Reports.* Apparently, not all physicians' offices recognize the difference between a medical *report* and a *copy* of medical records. "Reasonableness" as it relates to the fee charged for a medical report includes consideration of the time necessary to review records if the patient and his or her treatment have occurred quite some time in the past or over a long period of time. The nature and length of the report will also be factors in the Committee's determination of reasonableness of a fee for preparation of a medical report.

3. *Depositions.* Some attorneys have complained that some physicians add a "premium" or "surcharge" on fees for videotape depositions as opposed to depositions in which only a court reporter is used. Videotape depositions are specifically authorized in federal and state court lawsuits. The Committee members are not aware of any reasonable basis on which a physician could justifiably add on a premium or surcharge simply because the electronic medium is used instead of the typed medium.

The Committee reminds both professions of one of the basic principles of the Code: as a matter of fairness and cooperation between the professions, the physician and the attorney should make arrangements for *reasonable* compensation to the physician for the time spent away from his professional practice. Elements to be considered are the complexity of the care and treatment of the patient's medical conditions, the length of time necessary to properly prepare for and confer about the deposition, the time spent in giving the deposition, and, of course, the nature of practice and degree of expertise of the physician involved.

Conclusion

The Committee urges all members of both professions to reread the Interprofessional Code and follow its guidelines. Throughout, the Code attempts to deal with, and provide guidelines for, the recognition and accommodation of all interests — the Court, the patient, the parties involved and the two professions involved. Neither profession may properly ignore the other interests involved — and should not do so. In the words of the Code: "Any abuse of this Code or violations thereof by a member of either profession should be brought to the attention of the Physician-Attorney Liaison Committee for determination to be made as expeditiously as possible."

Physician-Attorney Liaison Committee
Thomas M. Marshall, MD
Physician Co-Chair
John T. Ballantine
Attorney Co-Chair

This article also appeared in the Kentucky Bench & Bar



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NIH Study for Patients at Risk for Stroke

The Division of Neurosurgery at the University of Kentucky Chandler Medical Center is studying patients who have significant atherosclerosis in the carotid arteries but who are as yet asymptomatic for stroke for TIAs. The study is being sponsored by the National Institutes of Health (NIH), and 15 medical centers nationwide are participating. The goal is to determine whether asymptomatic patients with greater than 60% carotid artery stenosis are best treated with endarterectomy plus aspirin or with aspirin alone. This important medical and economic issue can be resolved only by a randomized prospective clinical trial.

Initial screening is done by non-invasive testing. A follow-up period of five years for risk factor modification and determination of outcome will be funded by the study. Physicians interested in referring asymptomatic patients with carotid bruits or proven carotid artery lesions are asked to contact the UK Medical Center at 1-606-233-5861 or 1-800-7KY-STROKE. Detailed information about the study is available.

Reminder

IF YOU HAVE NOT ALREADY SIGNED UP, IT'S NOT TOO LATE!

You are invited to participate in the Referral Directory of Specialists Section of the 1989 Membership Directory of the Kentucky Academy of Family Physicians.

To be included, there will be a fee of $25.00 per Physician name listed. This will cover 1-4 lines. For more details contact:

KAFP HEADQUARTERS
3323 Medical Arts Bldg.
Louisville 40217
AC 502/451-0370

Deadline for placement: November 1, 1988.

October
Certification Training Program leading to Certification in Cognitive-Behavior Therapy, Charter Ridge Hospital, Lexington, KY. Nine-month Training Program beginning October 1, 1988 to be held once monthly for six months, then twice monthly for the last three months. Contact: Tonya Fleming, Charter Ridge Hospital, 3050 Rio Dosa Dr, Lexington, KY 40509-9990, (606) 269-2325, ext 212.

October 12-13
Care of the Seriously Ill Child — The 16th Annual Fall Pediatric Surgery/Pediatrics Symposium concerning "Acute Pediatric Emergencies," Lincoln Hotel and University Conference Center, Indianapolis, IN. Sponsored by the Indiana University School of Medicine. Contact: Jay L. Grosfeld, MD, (Symposium Director) Surgeon-in-Chief, Riley Hospital, 702 Barnhill Dr, Indianapolis, IN 46223, (317) 274-8353.

October 20-22
Advanced Trauma Life Support, University of Kentucky College of Medicine. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

October 22
Community Symposium — "AIDS the Disease of the 80s," Hyatt Regency, Lexington. Contact: Mrs. John W. Collins, 2035 Bridgeport Drive, Lexington, KY 40502, (606) 269-3048 or 268-4554.

October 28
Suicide: Interprofessional and Community Responses, The Ohio State University's Twenty-fourth Semiannual Interprofessional Continuing Education Conference, Hilton Inn-North, Worthington, OH. Contact: Carlton Weber, The Ohio State University, 100 Oxley Hall, 1712 Neil Ave, Columbus, OH 43210-1219, (614) 292-5621.

October 30-November 4
Nineteenth Family Medicine Review — Session III, Hyatt Regency Hotel, Lexington, KY. Sponsored by the University of Kentucky College of Medicine. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

November 10-11
22nd Annual Newborn Symposium, Kosair Children's Hospital Auditorium, 200 E Chestnut St, Louisville, KY. Larry N. Cook, MD, Professor and Associate Chairman, Department of Pediatrics, will be Program Chairman. Contact: Linda S. Ecker, Academic Coordinator, Department of Pediatrics, School of Medicine, University of Louisville, Louisville, KY 40292, (502) 562-8826.

November 19
"Multidisciplinary Treatments of Chronic Pain," Pritchard Community Center, Elizabethtown, KY. Sponsored by the Medical Staff of Lakeview Rehabilitation Hospital, Elizabethtown. Contact: Kim Maddox, Lakeview Rehabilitation Hospital, 134 Heartland Dr, Elizabethtown, KY 42701, (502) 769-3100.

December 7-9
American Cancer Society, National Conference on Advances in Cancer Management, Hyatt Regency Hotel, Los Angeles, California. Contact: American Cancer Society, National Conference on Advances in Cancer Management, 3340 Peachtree Rd, NE, Atlanta, GA 30026 (212) 599-3600.

December 13-15
Advanced Trauma Life Support, University of Kentucky College of Medicine, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

December 16-17
Vascular Surgery Update, Hyatt Regency Hotel, Lexington, KY. Sponsored by the University of Kentucky College of Medicine. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

February 19-24, 1989
Twentieth Family Medicine Review — Session I, Hyatt Regency Hotel, Lexington, KY. Sponsored by the University of Kentucky College of Medicine. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

U OF L TO TEACH CRITICAL CARE NURSING IN RURAL HOSPITALS— The University of Louisville School of Nursing is beginning a three-year project to offer critical care training for nurses in Kentucky's rural hospitals. Classes on the care and treatment of patients with pulmonary, neurological, gastronintestinal, renal, endocrine, cardiovascular, burn and trauma problems will be taught at centralized, non-urban locations throughout the state. Contact: Barbara Dermody, Project Director, at (502) 588-5366.

Health Fraud Conference
Campbell House
Lexington, KY

October 27

Sponsors include:
the University of Kentucky Cooperative Extension Service, Kentucky Dietetic Association, University of Kentucky School of Nursing and the Attorney General's Health Fraud Task Force.

Contact:
Darlene Forester, PhD, RD
University of Kentucky
120 Erikson Hall
Lexington, KY 40506
(606) 257-1812

Health and Safety Tip From the American Medical Association

MARKERS LISTED TO IDENTIFY ALCOHOLICS

How can you tell that a regular, heavy drinker has crossed over the line and become an alcoholic, who no longer can control his or her drinking?

The American Medical Association in its Manual on Alcoholism points to some markers to help identify the alcoholic.

1. Increasing consumption of alcohol, with frequent, perhaps unintended, episodes of intoxication.

2. Drinking to handle problems or relieve symptoms.

3. Obvious preoccupation with alcohol and the frequent need to have a drink.

4. Surreptitious drinking or gulping of drinks.

5. Tendency toward making alibis and weak excuses for drinking.

6. Refusal to concede what is obviously excessive consumption and expressing annoyance when the subject is mentioned.

7. Frequent absenteeism from the job, especially following weekends and holidays.

8. Repeated changes in jobs, particularly if to successively lower levels, or employment in a capacity beneath ability, education and background.

9. Shabby appearance, poor hygiene, and behavior and social adjustment inconsistent with previous levels or expectations.

10. Persistent vague physical complaints without apparent cause, particularly insomnia, stomach upsets, headaches, loss of appetite.

11. Multiple contacts with the health care system with disorders that are alcohol caused or related.

12. Persistent marital and family problems, perhaps with multiple marriages.

13. History of arrests for drunkenness or drunken driving.

Submitted by the KMA Impaired Physicians' Committee

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Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

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FOR PHYSICIANS: UNSECURED SIGNATURE LOANS $5,000-$60,000. Available for purchase of medical practices, relocations, or any other need including taxes. No points or fees. Best rates. Level payments up to six years. No prepayment fees. For application call Toll Free 1-800-331-4952, MediVersal Dept. 114.

FOR RENT — St. Augustine Beach, Fla. 3 Br, 2 Bath Condo. Well Furnished, Ocean Side, Overlooking Lagoon. $450 per week. (904) 285-0556; (502) 426-8615.

STAFF RADIOLOGIST needed for large dept. at progressive, new 380+ bed hospital in western Kentucky community of 126K pop. University setting w/high standard of living and many cultural and recreational activities. BE/BC & well versed in all disciplines. Above average salary & benefits pkg. Contact Kathy Hetz, TYLER & COMPANY, 9040 Roswell Rd, Atlanta, GA 30350. Call 404-641-6411.

SOUTHEASTERN KENTUCKY — Moonlighting opportunity in moderate volume emergency department. Attractive hours. Malpractice insurance provided. Benefit package available to full-time physicians. Contact: Emergency Consultants, Inc., 2240 South Airport Road, Room 31, Traverse City, MI 49684; 1-800-253-1795 or in Michigan 1-800-632-3496.

FOR SALE — 60W CO_2 Laser. Excellent Condition. Olympus Laparoscopy Equipment including Scopes and Insufflator. Contact Dan Hauck, PO Box 397, Shelbyville, KY 40065.

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- **Public Information Services** Sources include CDC, the Surgeon General and NLM/NIH.
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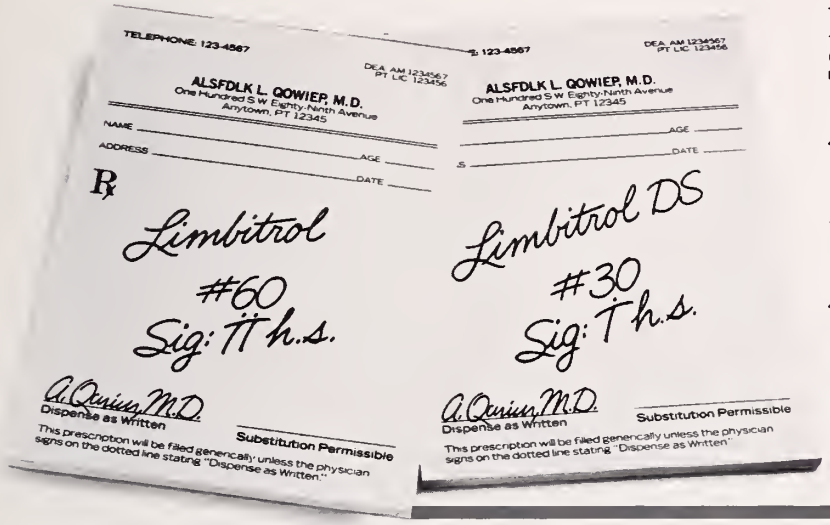
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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61:*217-225, Mar 22, 1979.

Limbitrol® Ⓥ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

How Supplied: *Double strength (DS) Tablets,* white, film-coated, each containing 10 mg chlordiazepoxide and 25 mg amitriptyline (as the hydrochloride salt), and *Tablets,* blue, film-coated, each containing 5 mg chlordiazepoxide and 12.5 mg amitriptyline (as the hydrochloride salt)—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 50.

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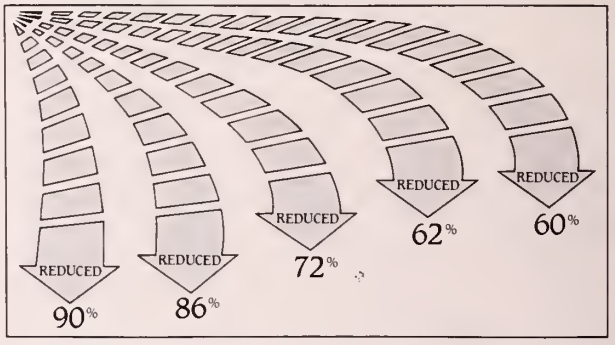
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- First-week reduction in somatic symptoms[1]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

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JOURNAL OF THE
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V. 86, NO. 11 COLLEGE OF PHYSICIANS OF PHILADELPHIA
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Welcome to Our New KMA Members

Page 630

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VOL 86 NO. 11
NOV 1988

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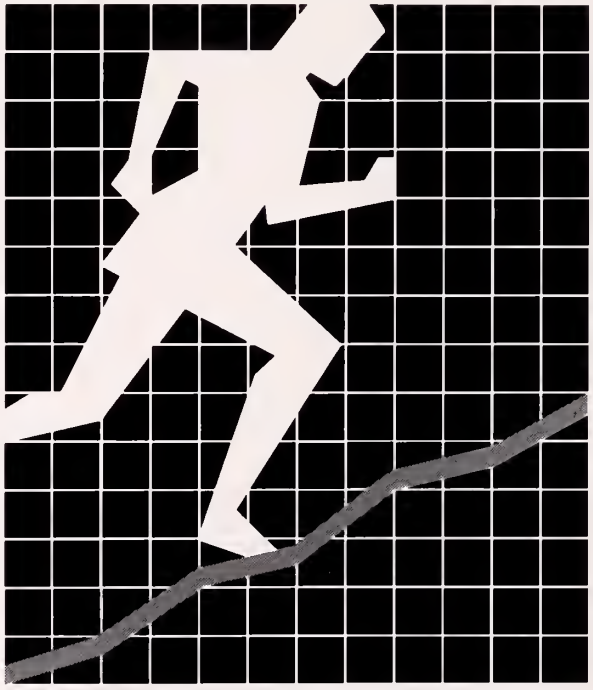
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TABLE OF

C O N T E N T S

November 1988

SCIENTIFIC

Evaluation of Knee Injuries Using Magnetic Resonance Imaging
John Vaughan, MD; Jan Klamar, MD; David Seligson, MD **605**

Hypertriglyceridemia Presenting as a Reversible Cause of Vertigo
Miles S. Snowden, MD; Roy J. Meckler, MD **609**

Hemorrhoids — Alternative Treatments *(Grand Rounds)*
Harold T. Faulconer, MD **617**

EDITORIAL

The Far Side of the Helix **623**

ASSOCIATION

A Welcome to Our New KMA Members **630**
Billy J. Mabry Joins KMA Staff **633**
Donna M. Young Promoted to Executive Staff **633**
KEMPAC Board Meeting **634**
"Athletic Drug Problems" **635**
Practice Management Workshops **636**
KMA 1988 Annual Meeting Highlights **637**
Committees **634**

REGULAR FEATURES

President's Page **601**
Auxiliary **629**
Book Reviews **625**
CME **627**
Classified **638**
Information for Authors **611**
Updates **632**

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November Buyer's Guide

Charleston Area Medical Center....603, 621
Classified....638
Computer Links Associates, Inc....616
Elcomp Systems, Inc....600
KMIC....622
KMIC Investment Company....596
Eli Lilly & Company....604
Marion Laboratories....612, 613
Medical Protective Company....615
MediGen of Kentucky....628
Naval Reserve Force....628
PIE Mutual Insurance Company....602
Roche Laboratories....639, 640
Signature, Inc....627
SynerSource, Inc....628
U.S. Air Force....624
U.S. Army Reserve....614, 626
VHA/Pediatric Anaesthesia Associates, P.S.C....624

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November is a special month for all of us. It is a time when we, a nation made up of many diversified groups of people, take a special day to proclaim Thanksgiving to Almighty God for the blessings of home and harvest, health and happiness that we Americans, for the most part, abundantly enjoy.

We in the health profession can proudly claim the highest type of medical practice in the world. We hope to keep our professional standards that way. We doctors and our patients know that, comparatively speaking, Americans enjoy the highest standards of health care and accessibility in the world.

During this Thanksgiving month, won't you stop with me and express your thanks for some of the things that we doctors often take for granted and forget to stay mindful of:

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Legislators and officials who dare to take the courage to speak up for quality health care and who help lead the fight to speak out so citizens can have some choices in health care.

Patients who commit themselves to our care. Patients who give us loyalty and respect as well as concern for our busy schedules and our great responsibilities — a concern which even extends to our own personal health and well-being.

Dedicated secretaries, clerks, office employees, and hospital workers who daily screen calls, answer questions, relay messages, and type or write correspondences and reports that save us time and steps and sometimes, patients' lives.

An efficient, professional KMA STAFF who put in long hours working to uphold the highest standards of medicine for the sake of our profession and our doctors here in Kentucky.

Hospital staff people who are willing to look at the broad ranges of medical needs and problems and who call upon staff doctors to get their input and ideas so that they can use that information to provide better services.

Friends, neighbors, and family members who accept us in the medical profession as fellow human beings, not perfect professionals who always have the right answers and clear-cut decisions.

Our fellow colleagues who strengthen and support us in immeasurable professional and personal ways.

This Thanksgiving, as you and I join our family members and gather around a bountiful table, we will be reminded that not every American has enough food to eat or decent housing or adequate medical care. We in the medical profession are committed to continuing our fight for these people, and we will always give our help to the indigent, the poor, and the elderly in any way that we can.

Angie joins me in wishing each and every one of you a Happy Thanksgiving. I remain thankful for the support from all of you in KMA.

Bob M. DeWeese, MD
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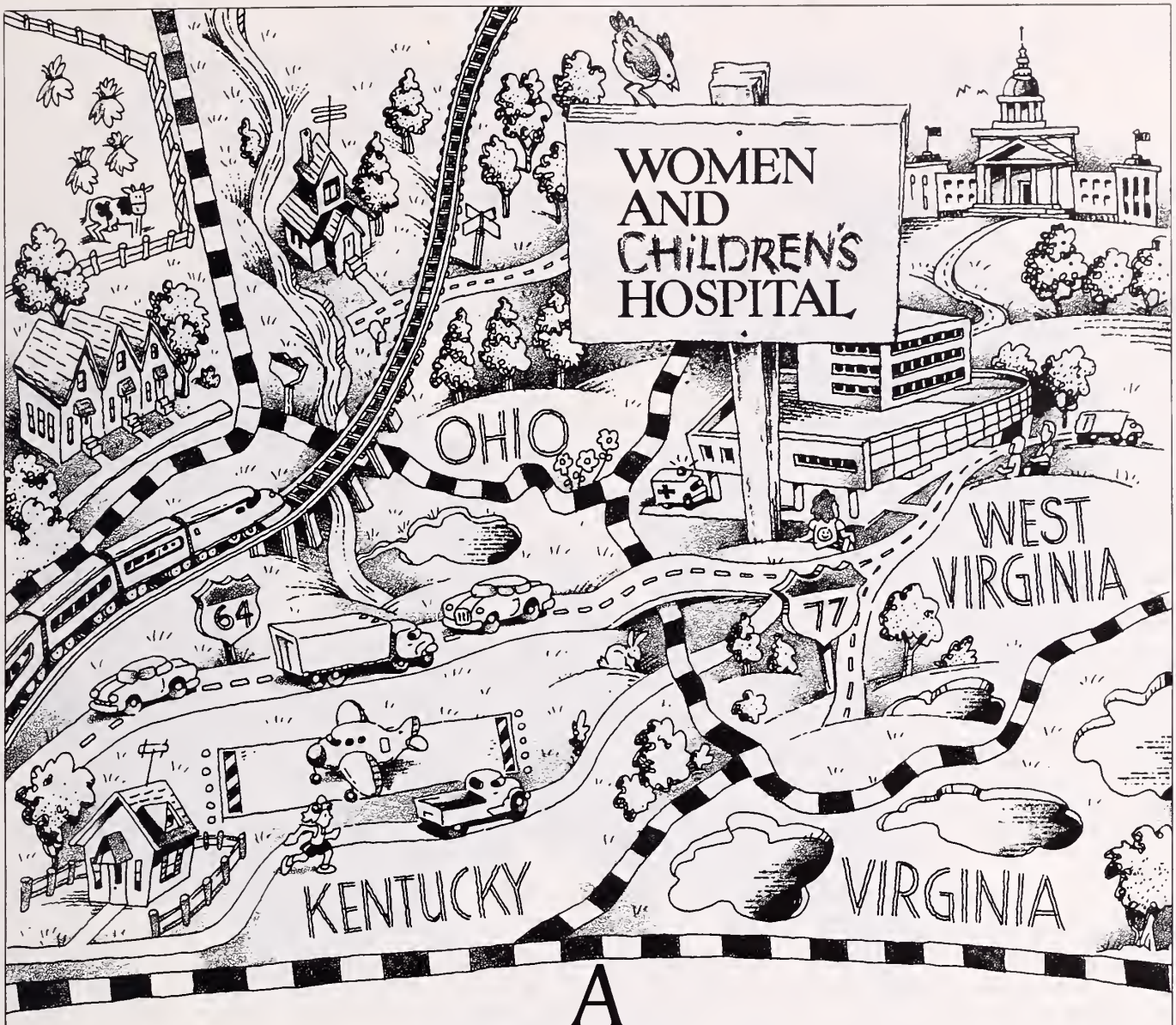
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Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea) 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.
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Evaluation of Knee Injuries Using Magnetic Resonance Imaging

From the Department of Orthopaedic Surgery, School of Medicine, University of Louisville, Louisville, KY 40292 (Dr Seligson).

John Vaughan, MD
Jan Klamar, MD
David Seligson, MD

Current methods of diagnosing soft tissue injuries to the knee include physical examination, arthrography, and arthroscopy. These methods may be inaccurate, expensive, and associated with known morbidity. Magnetic resonance imaging utilizes signals produced by the hydrogen nucleus in tissue to form an image of the tissues. MRI produces images of the knee with excellent soft tissue contrast which allows easy identification of soft tissue lesions. The MRI is an accurate method of diagnosing meniscal tears, cruciate ligament tears, patellar tendon disruptions, and a variety of other lesions. MRI evaluation of knee injuries allows the detection of those lesions requiring surgical treatment while avoiding unnecessary negative diagnostic arthroscopies.

Introduction

Evaluation of knee injuries is a common clinical problem. Physical examination, arthrography, and arthroscopy are the mainstays of diagnosis of knee injuries. These methods have limitations though. Physical examination for joint laxity may be less than accurate even in experienced hands.[1] Arthrography can achieve high diagnostic accuracy, but it requires the injection of contrast agents, exposure to ionizing radiation, and the need to apply stress to a knee that is already painful.[2] Diagnostic arthroscopy is currently thought to be the most sensitive evaluation of the ligaments and menisci of the knee. However, this method is invasive, time consuming, requiring of an anesthetic, and associated with known morbidity.[3]

Magnetic resonance imaging (MRI) has unique advantages over these other modalities. MRI provides a multiplanar view of the knee with detailed images of both intra-articular and extra-articular soft tissues. It is non-invasive, painless, and has no known adverse biologic effects. MRI is only contraindicated in patients with cerebral aneurysm clips, which may torque on vessels, and cardiac pacemakers, which are converted to a fixed rate by the magnetic field.

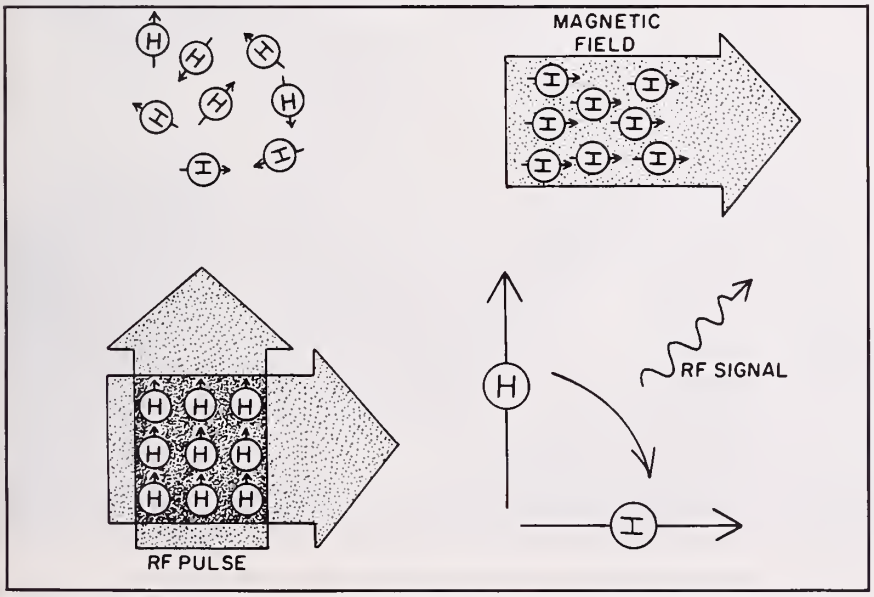


Fig 1. (a) hydrogen nuclei with randomly oriented magnetic poles; (b) Alignment of hydrogen nuclei in applied magnetic field; (c) 90° tilt of hydrogen nuclei with applied RF pulse; (d) RF signal produced as nuclei return to original alignment.

Magnetic Resonance Imaging

Magnetic resonance imaging has the ability to image biological tissue containing atoms with an unpaired proton or neutron (^{1}H,^{13}C,^{23}Na,^{31}P, etc). Hydrogen (^{1}H) is used because of its abundance in body tissues and its strong signal. MRI is based on two characteristics of the proton in the hydrogen nucleus: the spin about its axis and its intrinsic charge. When placed in a strong magnetic field, the normally randomly oriented nuclei align themselves parallel to the applied magnetic field. A sequence of radiofrequency (RF) pulses is then applied which cause the nuclei to tilt 90° to the plane of the magnetic field. When the RF pulse is terminated, the nuclei return to their original alignment and a weak RF signal is produced which is detected by a receiver coil (Fig 1). Powerful computers analyze and correlate the RF signals and produce an image of the subject tissue. The process of stimulating a sample with a RF pulse and detecting the emitted RF signal is termed magnetic resonance.[4]

Conventional roentgenograms demonstrate boney structures well, but provide poor soft tissue contrast. The high speed computers used in MRI detect subtle differences in soft tissue signals to produce images on conventional x-ray film with excellent soft tissue contrast. Nearly all soft tissue involved in pathologic lesions are clearly identified on MRI.

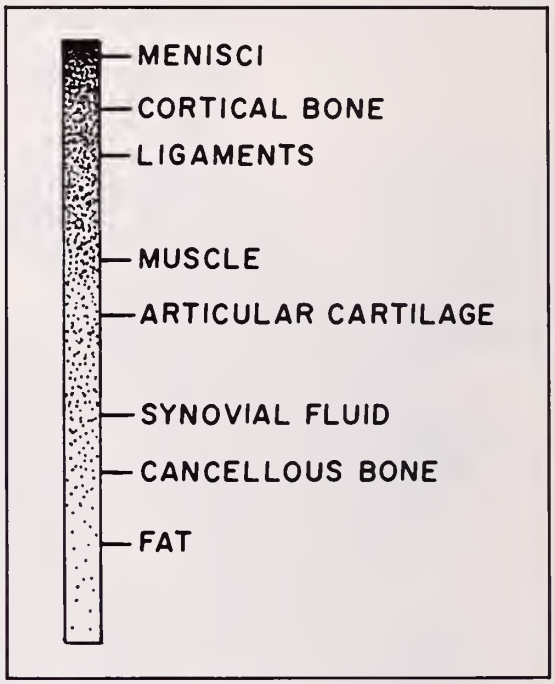


Fig 2. Signal intensities of various structures of the knee.

Normal Anatomy

The knee is routinely imaged in the coronal and sagittal planes on MRI. The structures in the knee are distinguished by their varying signal intensities (Fig 2). Cortical bone, ligaments, and menisci have a low signal intensity and appear black on MRI. Muscle and articular cartilage are intermediate in density and appear gray. Fat and cancellous bone have a high signal intensity and appear white (Fig 3).

Evaluation of Knee Injuries

Meniscal tears are common injuries which can be accurately diagnosed with MRI. Meniscal tears are seen as a linear bright area in the normally dark appearing substance of the meniscus (Fig 4). It is generally presumed that the high intensity area represents synovial fluid in the tear, creating an arthrogram effect. More subtle changes such as minimally increased signal intensity within the meniscus may represent early degenerative change of the meniscus. The use of MRI in detecting meniscal injuries has found value in two regards: (1) the predictive value of a negative MRI approaches 100%, so a clinically suspect knee with a negative MRI may eliminate the need for arthroscopy and (2) MRI may precisely depict the location of a meniscal tear thus facilitating arthroscopic detection of lesions that might otherwise go undetected.[5]

Ligamentous injuries of the knee which are demonstrated by MRI include tears of the anterior cruciate ligament (ACL), posterior cruciate ligament (PCL), medial collateral ligament (MCL), and lateral collateral ligament (LCL).

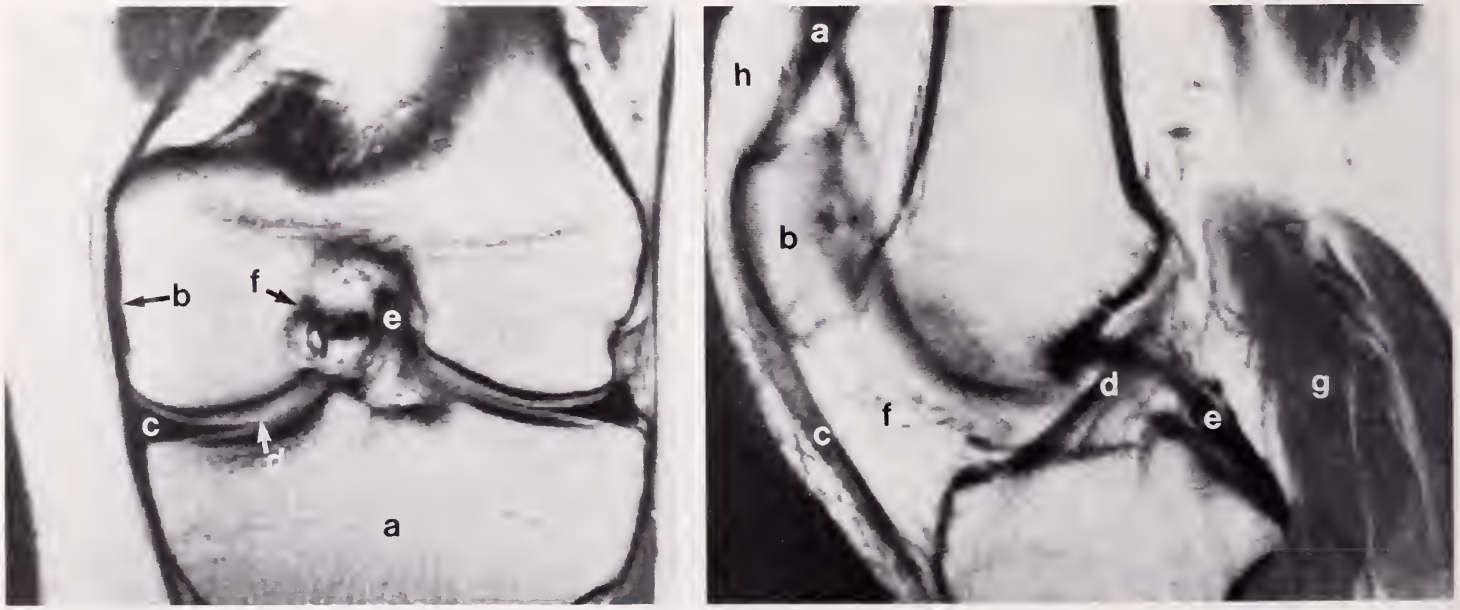


Fig 3. Left — Coronal view of left knee demonstrating: (a) cancellous bone; (b) cortical bone; (c) meniscus; (d) articular cartilage; (e) origin of anterior cruciate ligament; (f) insertion of posterior cruciate ligament.
Right — Sagittal view of same knee demonstrating: (a) quadriceps tendon; (b) patella; (c) patellar tendon; (d) anterior cruciate ligament; (e) posterior cruciate ligament; (f) synovial fluid; (g) muscle; (h) fat.

The ACL is seen arising from the anterior intercondylar area of the tibia and extending backward to attach to the medial aspect of the lateral femoral condyle. The posterior cruciate ligament arises from the posterior intercondylar area and passes forward to attach to the lateral surface of the medial femoral condyle. Tears of the ACL and PCL appear on MRI as a disruption in the normal homogenous dark band or the complete absence of the structure in its normal anatomic position (Figs 5,6). It is often necessary to examine successive sections to determine the integrity of these obliquely situated structures.

Tears of the MCL and LCL are associated with cruciate ligament injuries. Tears of these ligaments are visualized on MRI as a discontinuity in the ligament or as an increase in the distance between bone and subcutaneous fat in the area of the ligament (this represents bleeding and edema in adjacent soft tissue). The use of MRI in detecting ligamentous knee injuries has a specificity and sensitivity of 97% to 100% and 73% to 100% respectively, according to various reports.[2,5,6,7]

Patellar tendon injuries are well depicted on MRI. There are three patterns of abnormality seen on MRI: (1) complete disruption of the normally continuous dark band representing the tendon with associated soft tissue swelling; (2) increased signal intensity within the tendon representing a partial tear; (3) a region of moderate signal intensity posterior to the tendon displacing the infrapatellar fat pad (Fig 7). It is believed that this is a hemorrhagic effusion of the infrapatellar bursa.



Fig 5. Sagittal view of knee with tear of the anterior cruciate ligament. Arrow indicates high intensity signal within the substance of the anterior cruciate ligament.

The appearance of many other pathologic

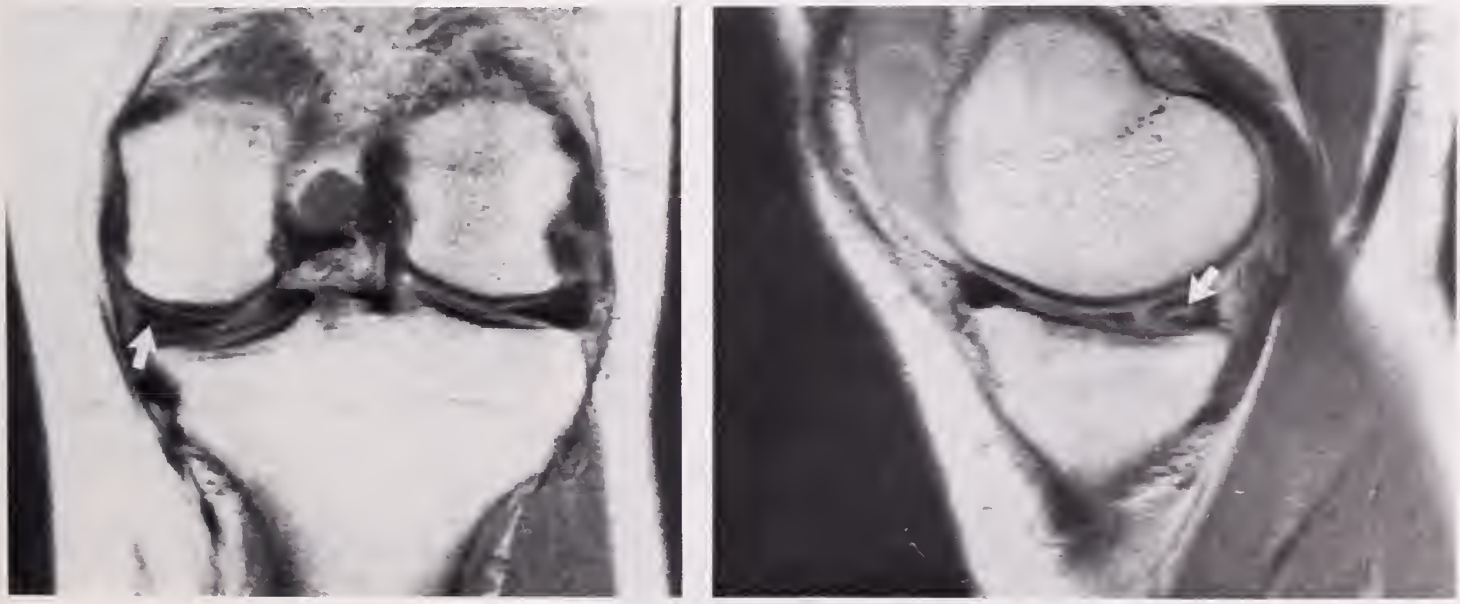


Fig 4. Coronal and sagittal views of right knee with tear in posterior horn of the medial meniscus. Arrow indicates high intensity within meniscus representing the tear.



Fig 6. Sagittal view of knee with tear of the posterior cruciate ligament. Arrow indicates high intensity signal representing disruption.

lesions of the knee on MRI has been described in the literature. This list includes chondromalacia patella,[8] medullary infarcts, osteochondritis dessicans, osteonecrosis, synovial cysts, tumors, joint effusions, Osgood-Schlatter disease,[9] and infections.[10]

Conclusion

When approaching knee injuries, the cornerstone of diagnosis remains the physical examination. Once a soft tissue injury is suspected by physical exam a practitioner may proceed to MRI of the knee as a diagnostic tool. The improved equipment and techniques of the last few years has allowed the demonstration of soft tissue lesions of the knee only previously shown by arthrography or arthroscopy. The large number of diagnoses that can be made from MRI of the knee allow it to be a very thorough evaluation of the knee. MRI of the knee can yield better preoperative information and diagnose unsuspected associated lesions while decreasing the amount of unnecessary surgery.



Fig 7. Sagittal view of knee with tear of the patellar tendon. Arrow indicates high intensity signal within normal dark substance of the patellar tendon.

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Hypertriglyceridemia Presenting as a Reversible Cause of Vertigo:
A Case Report and Review of the Literature

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A young man presented with vertigo and headache. His only laboratory abnormality was hypertriglyceridemia. Treatment of hypertriglyceridemia with weight loss, low saturated fat, low carbohydrate, high protein diet, and nicotinic acid eliminated vertigo and headache. Symptoms returned when noncompliance led to elevated triglycerides. Return to prescribed treatment again relieved the vertigo. Hyperlipidemias have been associated with such inner ear disorders as hearing loss, tinnitus, and vertigo. Platelet hyperaggregability, decreased fibrinolytic activity, increased blood fibrinogin, and increased plasma vicosity have all been proposed as mechanisms for the association. Treatment is aimed at lowering triglyceride levels with weight loss, dietary changes, and lipid-lowering drugs.

Case Report

A 30-year-old white man complained of intermittent vertigo and headache for one year. Although the vertigo occasionally occurred at rest, it characteristically occurred during exertional hyperventilation, such as during sexual intercourse. The patient also related that as a regular fisherman, he had been forced on several occasions to lie down in the bottom of his small boat to avoid falling out during his vertiginous episodes. The headaches often, but not always, accompanied the vertigo. They were posterior cervical, dull, constant, and aching in character. The headaches were often accompanied by alterations in thinking and were clearly precipitated by exercise.

The patient took no medication and had no history of medical illness. An aunt had recurrent pancreatitis thought to be secondary to severe hypertriglyceridemia.

Physical examination and neurologic examination were unremarkable. Complete blood count and urinalysis were normal. A non-fasting SMA-18 showed a triglyceride of 531 mg/dl. RPR and FTA were non-reactive. Serum immunoelectrophoresis was normal as was a hepatitis profile and thyroid profile. Erythrocyte sedimentation rate was 0 mm/hr. An ANA was positive at 1:80 dilutions in a speckled pattern, while an anti-double stranded DNA was less than 1:10. Both a chest x-ray and resting electrocardiogram were normal. 2-D echocardiogram was unremarkable.

Brainstem auditory evoked responses and audiograms were normal. Opticokinectic nystagmus was abnormal and ENG showed spontaneous left-beating nystagmus and a 35% reduction in vestibular response on the right. Computed tomography of the head was normal while a magnetic resonance scan was thought to be abnormal, with scattered, bilateral, deep white matter bright signals suggestive of a demyelinating process or vascular lesions. An electroencephalogram was suggestive of a seizure focus with hyperventilation. Diagnostic trials of clonazepam, phenytoin, and acetazolamide each produced no effect. The spinal fluid was normal for cells, glucose, protein, VDRL, IgG index, oligoclonal bands, and cytology. Pattern-reversed, visual-evoked responses were mildly abnormal bilaterally. An otolaryngologic evaluation, including external ear examination, fistula testing, and bithermal calorics, was normal. Twenty-four hour ambulatory EEG and EKG were normal during documented vertiginous episodes. A 14-hour fasting triglyceride level was 820 mg/dl, with a cholesterol of 170 mg/dl, and lipoprotein phenotype was type IV.

The patient was 89 kg in weight and 158 cm in height. He was instructed to lose weight and follow a low saturated fat, low carbohydrate, and high protein diet. He was gradually titrated to 2 g daily of slow-release nicotinic acid preparation.

Three months after carefully adhering to the prescribed diet he lost 10 kg and, with the prescribed nicotinic acid, had been without vertigo or significant headache for two months. Fasting triglycerides were 132 mg/dl and cholesterol was 144 mg/dl. Six months later the patient reported return of both vertigo and headaches after a 10 kg weight gain and both dietary and drug noncompliance. Fasting triglycerides were 785 mg/dl and cholesterol was 285 mg/dl. Six months later, after improving compliance he became symptom free with a fasting triglyceride level of 151 mg/dl and cholesterol of 170 mg/dl.

In summary, this previously healthy 30-year-old man presented with a one-year history of headache and vertigo most frequently on exertion. An intensive neurologic evaluation was non-diagnostic, although either multiple sclerosis or microvascular pathology was suggested. The major laboratory abnormality was a severe fasting hypertriglyceridemia. Correction of the elevated triglyceride level with weight loss, dietary

changes, and nicotinic acid resulted in resolution of all neurologic symptoms. Dietary and drug non-compliance allowed return of both neurologic symptoms and the hypertriglyceridemia. Finally, headache and vertigo once again proved reversible with return to compliance with the triglyceride-lowering measures.

Discussion

The relationship between hyperlipoproteinemia and inner ear disease was first suggested by Rosen after his study of the Mabaan tribe in 1960.[1] He observed that in civilized societies with high degrees of stress and high fat diets the incidence of hearing loss was greater than in the Mabaans, a primitive culture with a low fat diet. It was his contention that increased blood vicosity and hypercoagulability led to plaque formation and occlusion of cochlear vessels, resulting in hearing loss.

Rosen's observation was largely ignored until 1973 when Spencer recorded observations of the association of hyperlipidemias with various manifestations of inner ear disease.[2] His interest in this association arose out of a personal experience. Spencer was suffering from a progressive, non-fluctuating hearing loss and episodic vertigo of some five years duration when he was found to have type IV hyperlipoproteinemia. Weight loss and a low saturated fat, low carbohydrate diet led to relief of vertigo and an 87% improvement in hearing.

Inspired by his personal experience, Spencer studied 300 patients with symptoms of inner ear disease consisting of hearing loss, tinnitus, or vertigo. Fifty-one percent were found to have lipoprotein abnormalities. Among these subjects identified with inner ear disease and a lipoprotein abnormality he reported many cases of complete or partial resolution of vertigo, hearing loss, or tinnitus with adherence to a low saturated fat, low carbohydrate diet, and weight loss in those who were obese.

In 1975 Spencer studied 444 subjects with inner ear disease.[3] Forty-six percent were found to have a hyperlipoproteinemia. Of these, over 80% were judged overweight. He found that a low saturated fat, low carbohydrate diet, coupled with weight loss in the obese, resulted in reduction or elimination of inner ear symptoms in a majority of those who were compliant. Fluctuating hearing loss improved or stabilized. Acute vertiginous attacks lessened or ceased. Headaches were among the first symptoms to improve. Spencer suggested that hyperlipidemia resulted in a reversible metabolic inner ear dysfunction.

In 1976 Gosselin and Yanick studied 90 patients with fluctuating hearing loss.[4] Ninety percent had headaches and 6.7% had vertigo. One-third of the 90 subjects were found to have an elevated serum triglyceride or cholesterol. Symptoms improved in most of those compliant with weight reduction and dietary alterations. All individuals with increased lipids had less tinnitus and ear fullness with treatment. Of those formally retested 50% had objectively improved hearing.

The association of hyperlipidemia to inner ear disease is generally well accepted despite the lack of controlled studies. Pillsbury suggests that any evaluation of an acquired sensorineural hearing loss or vertigo should include a battery of metabolic tests to measure thyroid function, glucose metabolism, and the lipoprotein profile.[5] He further states that the reversibility of inner ear disease due to increased lipids suggests increased blood viscosity leading to decreased flow through the cochlear vessels as the cause of dysfunction, rather than arteriosclerosis.

Lehrer et al investigated the incidence of arteriosclerosis in patients with vertigo and elevated triglyceride levels.[6] They performed carotid ultrasonography on 28 such patients. Only one patient had evidence of atherosclerosis on ultrasound. Therefore, it seemed that large vessel anterior circulation arteriosclerosis was not the mechanism by which an elevated triglyceride level led to inner ear disturbances such as vertigo. Abnormal insulin response curves in all these vertiginous, hypertriglyceridemia patients suggests that insulin resistance or abnormal insulin receptor function may play a role in the inner ear dysfunction. Depressed cellular insulin binding could result in inner ear or central nervous system dysfunction due to episodic glucose deficiency or electrolyte imbalance with resultant vertigo. Both obesity and elevated triglyceride levels are associated with insulin resistance. Weight loss or correction of hypertriglyceridemia could improve inner ear function by improved insulin binding at the end organ.

Other investigators have suggested various additional explanations for the linkage of hypertriglyceridemia to inner ear disturbances.[7,8] Platelet hyperaggregability, decreased fibrinolytic activity, increased blood fibrinogen, and increased plasma viscosity have all been shown to be associated with an elevated serum triglyceride

and each could produce reduced capillary blood flow through the inner ear, local tissue hypoxia, and subsequent organ dysfunction.

Whatever the mechanism, a substantial number of uncontrolled studies and various anecdotal case reports such as ours reported here strongly suggest that hypertriglyceridemia may be a treatable cause of vertigo, tinnitus, hearing loss, and associated headache. Any patient with these symptoms should have fasting serum triglyceride and cholesterol levels included in their evaluation. In the patient with inner ear dysfunction elevated triglyceride levels should be treated with weight loss, dietary alterations, and, if needed, lipid-lowering drug.

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DOSAGE AND ADMINISTRATION
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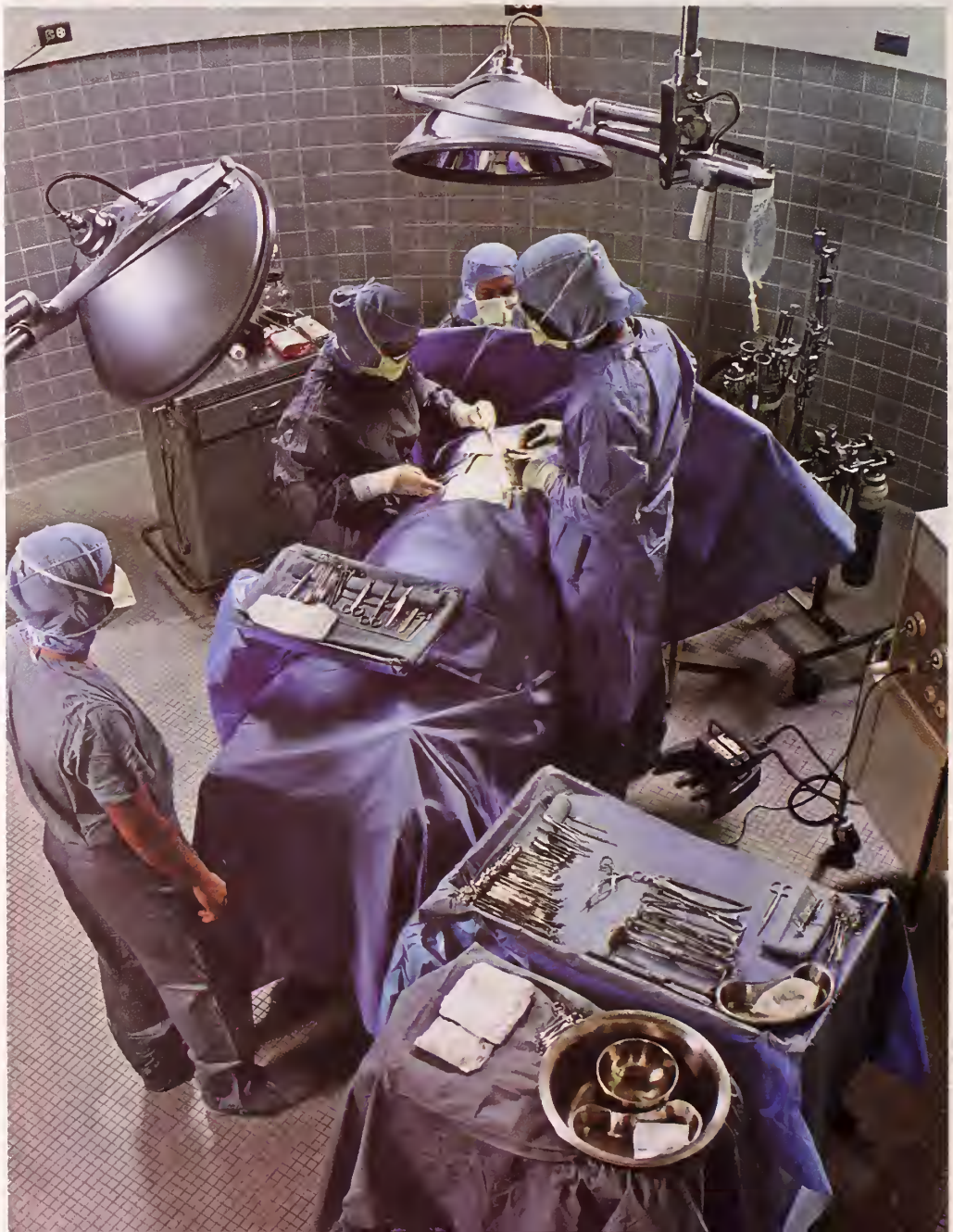
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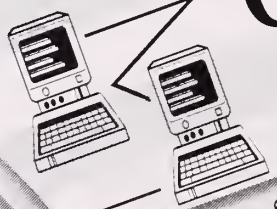
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Hemorrhoids — Alternative Treatments

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Harold T. Faulconer, MD

The concept of what hemorrhoids are has changed. We were taught for years that hemorrhoids were varicose veins in the anal area and that hemorrhoidal veins provided a communication between the systematic and portal systems. Hemorrhoidal bleeding, however, is bright red in nature, thus it is arterial. The blood encountered in hemorrhoidal surgery is bright red, thus arterial. The incidence of hemorrhoidal problems in patients with portal hypertension is no greater than in the normal population. Incidents of bleeding anal varices associated with portal hypertension are rare case reports. Orloff reported only *five* cases in *1,100* patients undergoing shunt procedures for portal hypertension.[1]

The current definition for hemorrhoids is that they are vascular cushions made up of arterioles, venules, and arteriolar-venular shunts in a pad of connective tissue in the submucosa being fixed to the internal sphincter by fibromuscular tissue.[2] These vascular cushions in the anal canal are present at birth and usually in three clumps, two being on the right and one on the left. They probably serve a function by adding a little bit to the continence mechanism. The door to your house keeps the bad weather out, but as an extra precaution you put weatherstripping at the base. You could consider hemorrhoids as being a little bit of weatherstripping or added insulation to anal continence. With the cushions being in quadrants, the anus can dilate with bowel movements without tearing.

The symptoms of hemorrhoids are primarily protrusion and bleeding. Pain is uncommon other than soreness unless there is associated pathology or thrombosis. Wetness, itching, and irritation are related to the prolapsing or difficulty in cleansing associated with external hemorrhoids. The symptoms of prolapse and bleeding are caused by loss of fixation of the anal cushions allowing the internal hemorrhoids to slide down, be scuffed, and protrude. These comments do not pertain to thrombosed hemorrhoids which present a separate pathological process.

There have been many ways of treating hemorrhoids; thus, there is no perfect way, that is, a painless treatment producing excellent results in all patients without complications. So the search goes on. There are few valid control studies of treatment; therefore, writers tend to promote the method with which they feel comfortable. As patients are ever seeking a painless cure, they tend to flock to and request the latest fad appearing in the lay literature. Unfortunately, as medical advertising is becoming more commonplace, this only adds to the confusion. Remember, all forms of treatment help some people some of the time. We are interested in what helps most of the people most of the time with minimum complications.

Treatment of hemorrhoids is primarily directed toward fixation of the anal cushions to prevent prolapse.[3] If the hemorrhoids are large, removal of tissue is important; but the current idea is that the more important aspect of treatment is fixation.

As regards treatment, the first form would be considered medical therapy. This would consist of encouraging better bowel habits to reduce straining at stool and decrease the shearing of the anal cushions. This would include such things as bulk stool softeners or high fiber diets. One would presume that straining at stool would encourage the anal cushions to shear thus producing prolapse.

In 1871, Dr. Mitchell in Clinton, Illinois, conceived the idea of sclerotherapy by injecting olive oil and carbonic acid into hemorrhoids.[4] This combination of injectables did produce rather severe slough at times and fell into disfavor. Weaker solutions were devised, and presently sclerotherapy is ordinarily done with 5% phenol in vegetable oil. The injection of this substance is into the mucosa and does produce mild inflammation with some resulting fibrosis and constriction of vessels but primarily helps by producing an adherence of the mucosa to the underlying internal sphincter thus welding the area. This is not like injecting a sclerosing substance into veins as is done with small varicose veins of the extremities. The induration usually lasts a few weeks after 3 to 5 cc of the solution are injected. Caution should be used when injecting. If the injection produces blanching, it is too superficial and this may lead to slough. Likewise, a deep injection may produce an abscess. Injection is probably best restricted to internal nonprolapsing hemorrhoids that bleed, and is a method of treating elderly, poor-risk patients who would not be suitable for more thorough treatment.

In 1954, Blaisdale developed a rubberband ligator,[5] and this was modified in 1962 by Dr. Barron.[6] A clump of internal hemorrhoids is grasped and a tiny rubberband is slipped around

the base of it. The strangulated tissue will slough in a few days. Some tissue is destroyed, but probably the prime action of therapy again is fixation at the sight of the slough. It is effective in many patients with small or moderate internal hemorrhoids that bulge and bleed. It is an office, out-patient type procedure. Complications are hemorrhage in about 1% when the slough occurs and thrombosis of external hemorrhoids in about 5% to 10% of patients. Most patients with small to moderate internal hemorrhoids are improved.[7] Banding is not used for external hemorrhoids, and most patients needing treatment have mixed internal and external hemorrhoids. In the past few years, there have been five deaths reported following banding procedures,[8,9] These cases were in the Western part of the United States and were not immunosuppressed patients. The mechanism may be related to the fact that *Clostridium perfringens* occurs in about 10% to 15% of normal colons, and in banding, a small clump of necrotic, gangrenous tissue is produced in which this anaerobe may flourish. A suggested way to prevent this serious complication is to inject the banded hemorrhoid with phenol in oil to sterilize the banded clump.[10] There have been several nonfatal cases that were diagnosed early and treated aggressively. All of these patients reported the three symptoms of pain, fever, and urinary retention, and anyone that does banding certainly should caution patients to report for immediate examination if any of these symptoms occur. Though the incidence of this severe complication is very remote, it has caused a decreased enthusiasm for the procedure.

The practice of cryotherapy, fortunately, has decreased. The concept here is cellular destruction of the hemorrhoid by rapid freezing around the tip of the cryoprobe with an iceball forming. The tissue is allowed to thaw and then the probe removed, as initially it is frozen to the tissue. The treatment does require sedation and at least a local anesthetic. Internal and external hemorrhoids can be treated. Probes devised utilize either liquid nitrogen which would lower the temperature to $-196^{\circ}C$ or liquid nitrous oxide which would reduce the tissue to $-89^{\circ}C$. Both of these cause freezing of the tissue for approximately two minutes. After treatment there is severe swelling and edema in the first 24 hours followed by a very copious watery drainage for three to four days lasting up to a couple of weeks. Patients require wearing a pad or diaper. About 72 hours after treatment red spots form which coalase about the fourth day. These turn black and gangrenous about the fifth or sixth day and finally the tissue disintegrates by about the 18th day.[11] One of the difficulties of this treatment is the inability to determine the exact depth of the thermal injury and the sphincter can be damaged. Cryotherapy is not painless. It leaves residual tags, causes severe drainage, requires expensive equipment, consumes time, and causes post-treatment hemorrhage in approximately 3% of the patients. One must wonder if there is a place in modern surgery for a treatment depending upon necrosis, gangrene, and slough.

Another concept of etiology of hemorrhoids is that they are related to an increased anal pressure. Anal dilation for the treatment of hemorrhoids was popularized by Dr. Peter Lord in 1968.[12] His initial cases were in patients with acutely thrombosed hemorrhoids, and as earlier noted, this is a separate type of hemorrhoidal disease in which hemorrhoids become thrombosed, protrude, and become strangulated by the sphincter mechanism. Stretching of the anal canal should cause some improvement of this condition, but as for nonthrombic hemorrhoids, there is more debate.

The Lord's procedure is classically an eight finger dilation avulsing the internal sphincter and stretching the external sphincters. This procedure, of course, requires an anesthetic, and a sponge is ordinarily placed in the anal canal for an hour or so to reduce hematoma formation. Most of the early reports of this procedure came from England where treatment such as this is more likely to be accepted. A five-year review of 100 patients reported by Walls-Ruckley[13] showed 75 of 100 patients as being free of symptoms, 22 patients having unsuccessful results, and 19 eventually requiring hemorrhoidal surgery. McCraffrey did a prospective review of 50 patients followed for four years, 36 being symptom free, four requiring hemorrhoidal surgery, and 40% having some degree of at least temporary incontinence.[16] At a recent meeting of the American Society of Colon and Rectal Surgeons, the audience was polled to see if anyone was doing the Lord's procedure, and no one acknowledged doing so. At the meeting in 1985, Dr. Mann[10] of St. Marks in London reported that even in England the Lord's procedure was in disfavor with the exception of selected young men who appear to have spastic sphincters. I am not aware of the procedure being utilized in any of the training programs in the United States.

If one believed that increased anal sphinc-

ter pressure was the cause of hemorrhoids, a more exacting means of treatment would be a lateral partial internal anal sphincterotomy in which a controlled sphincterotomy could be done. The internal sphincter does have value in the continence mechanism in that it is that portion of the sphincter musculature which is always contracted or tonic with the exception of relaxation during bowel movements or voiding. The most common cause of incontinence is the aging process, and rectal surgeons are very cautious about doing any type of sphincterotomy in patients over about 55 because of the increased instance of incontinence that follows.

Recently, much publicity has been given to the Infrared Coagulation procedure.[15] This is an infrared light with photo conduction of the light energy which is converted to heat energy in the tissue. The quantity of heat and depth of penetration are predictable. There is a sapphire tip which does not adhere to the burnt tissue. Depth of penetration is determined by a present timer of 1-1.5 seconds. There is an immediate blanch of burnt tissue which darkens over five to seven days and then scars. Results compare well with banding and there have been no reports of severe slough or infection and only rare post-treatment bleeding. There may be a sensation of warmth or brief pain during the procedure which patients can tolerate if forewarned. Ordinarily, one hemorrhoidal complex receives a burn at the apex and on each side of the apex at one treatment session. This form of treatment can be used for small to moderate internal hemorrhoids which bleed or cause mild prolapsing. It is not suitable for hemorrhoids with large protrusion or for external hemorrhoids.

The most recent modality for hemorrhoidal treatment is the laser.[16] The Yag Laser can be used with the flexible sigmoidoscope with the tip being directed back down to the internal components. These internal hemorrhoids are burnt producing some tissue destruction but primarily acting as a spot weld. If this is done, one should be careful to do only in specific quadrants as circular burns can produce stricture.

The Yag Laser can also be utilized by way of the anoscope in the operating room with the internal hemorrhoidal components being vaporized. Of the few studies reported, the urinary retention rate was similar to that of operative treatment and the healing time essentially the same. Abscesses have been reported from deep destruction and sphincter injury is a potential problem. The CO_2 Laser which produces a more superficial burn can be utilized by way of the anoscope, burning the apex of the column and then vaporizing the hemorrhoid, leaving the wound open. Complications reported have been similar to operative surgery.

The standard treatment for hemorrhoids is surgical excision of the hemorrhoids and associated anal pathology. The main drawbacks, of course, are pain and hospitalization. The results, however, are definitely superior with 95% of the patients showing improvement.[17] Most surgeons now utilize a closed technique in excising the columns of hemorrhoids and associated external tags.[18] Associated anal pathology can be treated at the same time. Hospitalization for approximately three days with pain medication is needed. Reports of out-patient surgery are sometimes deceptive, because frequently only partial hemorrhoidectomy is done in which one or two quadrants are excised. Complications of hemorrhoidal surgery include pain, urinary retention (particularly in young males), and postoperative hemorrhage (in approximately 1% of patients) occurring in seven to 14 days and requiring operative management. Infection is extremely rare; stricture associated with proper follow-up and good bowel movement habits is very remote.

In selected cases, sclerotherapy, banding, and infrared coagulation have a place, particularly in patients with bleeding internal hemorrhoids without significant prolapse. However, I believe that hemorrhoidal surgery is the standard to which all forms of treatment must be compared. The main drawbacks are pain and hospitalization, but the end results justify the means.

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Health and Safety Tip From the American Medical Association

MARKERS LISTED TO IDENTIFY ALCOHOLICS

How can you tell that a regular, heavy drinker has crossed over the line and become an alcoholic, who no longer can control his or her drinking?

The American Medical Association in its Manual on Alcoholism points to some markers to help identify the alcoholic.

1. Increasing consumption of alcohol, with frequent, perhaps unintended, episodes of intoxication.

2. Drinking to handle problems or relieve symptoms.

3. Obvious preoccupation with alcohol and the frequent need to have a drink.

4. Surreptitious drinking or gulping of drinks.

5. Tendency toward making alibis and weak excuses for drinking.

6. Refusal to concede what is obviously excessive consumption and expressing annoyance when the subject is mentioned.

7. Frequent absenteeism from the job, especially following weekends and holidays.

8. Repeated changes in jobs, particularly if to successively lower levels, or employment in a capacity beneath ability, education and background.

9. Shabby appearance, poor hygiene, and behavior and social adjustment inconsistent with previous levels or expectations.

10. Persistent vague physical complaints without apparent cause, particularly insomnia, stomach upsets, headaches, loss of appetite.

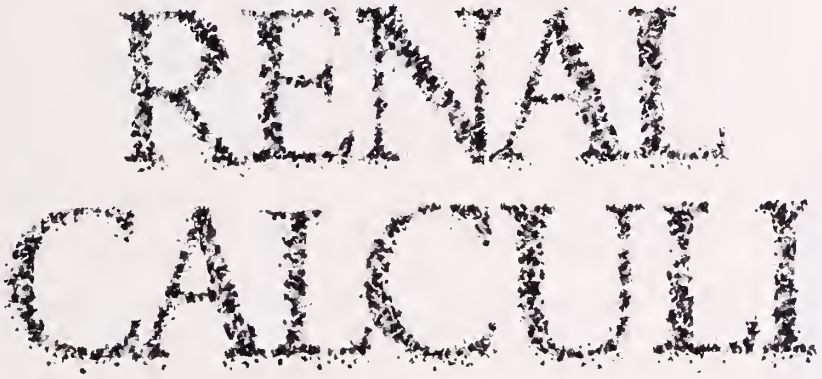
11. Multiple contacts with the health care system with disorders that are alcohol caused or related.

12. Persistent marital and family problems, perhaps with multiple marriages.

13. History of arrests for drunkenness or drunken driving.

Submitted by the KMA Impaired Physicians' Committee

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The Far Side of the Helix

And now these three remain: faith, hope, and love. But the greatest of these is love. I Corinthians 13:13

This time I'm going to discipline myself. Here is a page that will speak not at all of the frightful things threatening medicine, of the absurdities, inanities, and stupidities that drive our adversaries. This month, in this column there will be no pining for the good old days, no dire predictions, no wistful waiting for the swing of the pendulum back to coherence and order. No negatives, no gloom — there will be time aplenty for that. Instead, in November, let's pause and thankfully gaze at the marvelous complexity of healing, the healing we see daily.

Healing Arts, we call them. Techniques were never so sophisticated as now, but Art can still be the physician's distinctive. So we can be grateful in this month of Thanksgiving for something we'll never understand completely — the nature of healing. Oh, we understand a lot. Enlarging the lumen of a strangled artery can nourish downstream tissues — often. An antibiotic may savage a bacterium's metabolism without doing too much to ours — usually. Borrowed organs or cells can substitute nicely — sometimes. We look with awe on the DNA helix, marveling at what has been deciphered, at the "three billion nucleotide letters that it takes to spell Human Being." But, as Barry Commoner says in commenting on the popular aphorism that DNA is the secret of life, "biology might be more wisely guided by the aphorism 'life is the secret of DNA.'"

One of the things I'm thankful about this month is that we, and even those much wiser than we, will never understand all there is to know about people. We know something of the healing process, but there is ever so much more that we do not, can not know; we will never know it all. What a blessing! What a burden to pretend to know it all!

Generously reminding us of our well-deserved need for humility are the cases that don't fit any rule or experience, the simple illnesses that prove fatal, the massively ill that can't live, but do. How satisfying it is that no patient and no healer is just like another.

Having recently joined the ranks of the unwell (metastatic CA, prostate) I've had some patient-type experiences. I'll spare you the details but it has been illuminating and has given hints of some of the elements that go into modern medicine. I've been called by my first name by bored and busy clerks one-third my age, threatened with a collection agency by a colleague's computer because of a delayed $12 payment (I paid at once!). I've sat in waiting rooms with my fellow patients, some looking quite well, some with pale porcelain skin, veins like cracks in the glaze, with deep, dark eyes and but a few wisps of hair. We've eyed each other silently, furtively, wondering. After a time we've been summoned in to see the doctor and we've wanted and gotten the very best and latest in techniques and experience. But we all, patients and physicians, sense the massive amount we do not know, the absurdity of promises and predictions. So then, on the other side of technique and experience begins the Healing Art. Real physicians are practitioners of this art and when they do we go away with nothing changed but feeling better, sensing care and concern and interest, wondering about inexplicable cures, getting determined, convinced that we're in good hands.

St. Paul was an ignoramus about DNA but he teaches us still about the far side of the helix, he teaches of Faith — a belief in something we've found real, and of Hope — "a poor guide but an excellent companion," and Love, a sovereign preference, and the most important of all. And all three are decidedly contagious. I wish there was a medical school course in Faith, Hope and Love.

I'm thankful in November of 1988 for the things we cannot measure, cannot prove, but still know. I'm thankful for healing that we cannot understand. 1988 is a great year!

David L. Stewart, MD

AIM HIGH

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SLEEP: A Scientific Perspective

A. Michael Anch, Carl P. Browman, Merrill M. Mitler, and James K. Walsh

Prentice Hall
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Sleep disorder medicine has become an integral part of many centers. Departments dedicated to research, evaluation, and treatment of these disorders can be found in many hospitals. Students in many disciplines are taught basic principles of this field on equal footing with many other aspects of their education. This book is written for the student and for graduates whose education did not include this relatively new specialty.

Early chapters discuss the science of sleep, defining the terminology used in the book and suggesting additional readings for the dilettante. In fact, almost thirty pages deal with what is *normal* sleep. Laboratory investigation has fostered the invention of machinery to analyze what is going on from a chemical, physiological, and biomedical perspective.

Biological rhythms of sleep are graphically demonstrated and the pathology from disruption of these rhythms is revealed.

Dreaming as a process is explained, giving an historical perspective and modern theories. The effect of pharmaceuticals on sleep and the dreaming process is very interesting for the reader.

Sleep disorders such as insomnia and narcolepsy are carefully defined, diagnosed, and treated, with excellent summaries and readings given. Disorders of excessive somnolence and disruptions of the sleep cycle are very appropriate for a physician to learn and treat. The interrelationships with medical disorders such as malignancy, alcoholism, drug abuse, aging, and central nervous disease and sleep disorders literally tie the book to modern medicine.

Excellent summaries at the end of each chapter and suggested readings make the book practical for many of us.

Stephen Z. Smith, MD

Payment in Full — A Guide to Successful Bill Collecting

Leonard Bendell

Triad Publishing Company
1110 NW 8th Avenue, Suite 32601
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Today's complicated, expensive world makes great demands on the physician, not only for his medical acumen but increasingly on his ability to practice medicine in an efficient manner.

Financial stability and viability are important to a healthy medical practice, allowing employees to function, care to be rendered, and facilities to be maintained.

Initially the book discusses the concept of "It's your money." Basically this requires us to consider our practice a business as well as a medical delivery system. Delinquent accounts must be recognized and appropriate policies determined for what should be collected.

The next two sections may be harder to digest. Bill Collection Principles might be a more appropriate title. This is not the usual fodder for the medical mind. Nevertheless, at least someone in the office, a manager or clerical staff, should be schooled in what collections require. Numerous examples of calls, letters, and other communication techniques are designed to arm the reader with basic skills for this type of work.

Legal questions are germane and briefly discussed. Apparently several regulatory agencies protect the public from creditors, so *BEWARE.*

Reviewing such a book for a medical journal is perhaps inappropriate, but nevertheless this information is available for our use.

Stephen Z. Smith, MD

THE ARMY RESERVE OFFERS NEW FINANCIAL INCENTIVES FOR RESIDENTS.



If you are a resident in Anesthesiology or Surgery*, the Army Reserve has a new and exciting opportunity for you. The new Specialized Training Assistance Program will provide you with financial incentives while you're training in one of these specialties.

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ARMY RESERVE MEDICINE. BE ALL YOU CAN BE.

November 9-11
First National Cholesterol Conference, Hyatt Regency Crystal City, Arlington, VA. Sponsored by the Coordinating Committee of the National Cholesterol Education Program. Contact: Jake Roberts, Conference Manager, The National Cholesterol Conference, Artery Plaza West, 4733 Bethesda Ave, Suite 530, Bethesda, MD 20814, (301) 951-3275.

November 10-11
22nd Annual Newborn Symposium, Kosair Children's Hospital Auditorium, 200 E Chestnut St, Louisville, KY. Larry N. Cook, MD, Professor and Associate Chairman, Department of Pediatrics, will be Program Chairman. Contact: Linda S. Ecker, Academic Coordinator, Department of Pediatrics, School of Medicine, University of Louisville, Louisville, KY 40292, (502) 562-8826.

December 7-9
American Cancer Society, National Conference on Advances in Cancer Management, Hyatt Regency Hotel, Los Angeles, California. Contact: American Cancer Society, National Conference on Advances in Cancer Management, 3340 Peachtree Rd, NE, Atlanta, GA 30026 (212) 599-3600.

December 13-15
Advanced Trauma Life Support, University of Kentucky College of Medicine, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

December 16-17
Vascular Surgery Update, Hyatt Regency Hotel, Lexington, KY. Sponsored by the University of Kentucky College of Medicine. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

February 19-24, 1989
Twentieth Family Medicine Review — Session I, Hyatt Regency Hotel, Lexington, KY. Sponsored by the University of Kentucky College of Medicine. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

February-May, 1989
Johns Hopkins University School of Medicine 30th Annual Postgraduate Institute for Pathologists in Clinical Cytopathology.
February through April 1989 — Home Study Course A; April 24 to May 5, 1989 — In-Residence Course B, a lecture series. Contact: John K. Frost, MD, or Ms. B. Clendaniel, 604 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, (301) 955-3522.

U OF L TO TEACH CRITICAL CARE NURSING IN RURAL HOSPITALS— The University of Louisville School of Nursing is beginning a three-year project to offer critical care training for nurses in Kentucky's rural hospitals. Classes on the care and treatment of patients with pulmonary, neurological, gastronintestinal, renal, endocrine, cardiovascular, burn and trauma problems will be taught at centralized, non-urban locations throughout the state. Contact: Barbara Dermody, Project Director, at (502) 588-5366.



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Sharing



Sharing is a principle we all try to give our young children. Unfortunately, it's a valuable, lifetime principle we often fail to use as adults. The National AMA Auxiliary is a prime example of available opportunities for sharing — sharing ideas, failures, and successes.

The Colorado Medical Auxiliary has successfully implemented and shared an outstanding legislative program. I think it goes without saying, the time has come for medicine to take an active role in the legislative process!

There are, of course, the tried and true lobbying efforts; but, the times call for more. The Colorado MINI-INTERNSHIP PROGRAM is a wonderful step in the right direction. The basic principle of the program is that of first-hand experience for the legislator and/or public official. A legislator spends the day with a physician — visiting the hospital, observing surgery and/or diagnostic procedures, seeing office patients, and visiting the doctors' lounges.

This program requires careful organization in both planning and in selection of legislators and physicians. We, in Kentucky, plan to try Colorado's MINI-INTERNSHIP PROGRAM this winter on a small, evaluative scale. If all goes well, Kentucky may have its own program, making our legislative efforts more effective.

Thanks to the Colorado Auxiliary for sharing through the Auxiliary to the AMA its successful and creative MINI-INTERNSHIP PROGRAM.

Mrs. Thomas Slabaugh (Sugar)
AKMA Legislation Chairman

A Welcome to Our New KMA Members

We are pleased to extend a warm welcome to our many new Kentucky Medical Association members, and we look forward to sharing in one of their most important professional relationships.

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New KMA members since the 1987 Annual Meeting, as of August 1, 1988.

Updates

Doctor Swikert Recognized for Membership Recruitment

Donald J. Swikert, MD, Florence, was recently recognized for his efforts in membership recruitment undertaken during the AMA Young Physicians Section Outreach Program. Doctor Swikert, who has served as a Kentucky Delegate to the AMA-YPS, received one of the top individual awards for recruiting 32 young physician members.

In addition, the Kentucky Medical Association was awarded a plaque as the top state in its category for the number of new members recruited in this campaign. The other state winners were Wyoming, South Carolina, Missouri and Ohio. The award presentations were made during the AMA Annual Meeting held in Chicago in June.

Three KMA Members Honored by Peers

Jerry B. Buchanan, MD, Prospect; Charles D. LeNeave, MD, Mayfield; and James Wendell Tyson, MD, Goshen, were recently named as fellows of the American College of Radiology (ACR) during ceremonies at the ACR annual meeting in Cincinnati, Ohio. Selected for their outstanding contributions to the field of radiology, these KMA members were named as three of 136 new fellows by the College's Board of Chancellors.

Fellowships in the College are awarded for significant scientific or clinical research in the field of radiology, or significant contributions to its literature. Criteria for selection also include performance of outstanding service as a teacher of radiology, service to organized medicine, and an outstanding reputation among colleagues and local community as a result of long term superior service.

KMA Member . . .
Auxilian . . .

Our readers are interested in the important events occurring professionally in the lives of their fellow members. Do you, or someone you know, have a newsworthy note to submit for possible publication in your *Journal of the KMA*?

If so, please submit in writing to:

KMA Journal
3532 Ephraim McDowell Drive
Louisville, KY 40205

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Billy J. Mabry Joins KMA Staff



Billy J. Mabry joined the KMA staff on August 22, 1988, as Director of Governmental Relations. Mr. Mabry holds a BS Degree in Business Administration, an MPA Degree in Financial Planning and Financial Administration, and received his JD Degree from the University of Kentucky College of Law.

Mr. Mabry has previous experience in State Government having worked with the offices of the Kentucky State Treasurer, Kentucky Secretary of State, and the Kentucky Health Planning and Developing Agency. He comes to KMA from the private practice of law where, among other areas, he engaged in a full range of legal activities for health care providers, including hospitals, long-term care facilities, HMOs, and physicians.

He will serve the Association in various capacities, will assist in KMA's legislative activities, and will staff several committees within the KMA structure.

Donna M. Young Promoted to Executive Staff



Donna M. Young has been promoted to the Executive Staff of the Kentucky Medical Association. Ms. Young graduated from Indiana University with a BA Degree in Journalism and Political Science. A former reporter for the *Courier Journal-Louisville Times*, Donna Young covered local elections and did feature stories and interviews on various candidates.

Ms. Young joined KMA staff in 1979 as Managing Editor of *The Journal of the Kentucky Medical Association*.

She serves the Association as Executive Assistant which includes responsibilities as Associate Executive Editor of the *Journal*, annual KMA Emergency Medical Care Seminar, Annual Meeting Scientific Meeting Program, and other committees of the Association.

KEMPAC Board Meeting



The KEMPAC Board of Directors held its second meeting of the year on August 11, 1988, at the KMA Headquarters Building.

The Board members selected candidates for KEMPAC to support in the General Election to be held on November 8th. More funds were available this year than ever before. The membership report showed an increase of over 17% from the 1987 year-end report.

Committees

The KMA **Committee on School Health, Physical Education, and Medical Aspects of Sports** met September 1, 1988, to evaluate the sports medicine seminars held during 1988. Each high school head coach in the high-risk sports of football, basketball, baseball, soccer, and wrestling are required by the State Board of Education to annually attend at least one symposium sanctioned by this Committee, and to be certified in CPR each year. Eight seminars were held throughout the state during 1988 and were well attended and well received. Each seminar has as program chairman a member of the School Health Committee.

The Kentucky High School Athletic Association has recommended to the State Board of Education that all head coaches in all sports sanctioned by KHSAA be required to attend a KMA-sanctioned sports medicine seminar on a biennial basis and that penalties be imposed upon any coach not complying with that directive.

The Committee is currently working on a "Sports Medicine Syllabus and Program Guide" for the purpose of providing a basic level of instruction in various aspects of sports medicine as they relate to the needs of coaches. A subcommittee was appointed to oversee the development of the Syllabus, and most articles have been completed by the assigned contributors. As soon as all papers are reviewed by the subcommittee, suggestions will be made on methods of providing this information to coaching staffs as a ready reference manual. The Committee believes this will also serve as an effective guide in the program development for the sports medicine seminars.

Two problems — late whistles and spear tackling — were reported by the Committee to KHSAA with the request that attention be given to these problems. KHSAA brought these matters to the attention of the officials at their sports clinics this year and asked for their cooperation in resolving these problem areas.

The Committee members continue to be concerned with the possibility of heat strokes among Kentucky's athletes due to the early start of football practice and the playing season and have expressed this concern to KHSAA and the State Board of Education.

The **Ad Hoc Committee on Foreign Medical Graduates (FMGs)** met to consider licensure requirements and procedures for FMGs. A representative from the Kentucky Board of Medical Licensure met with the Committee and explained that U.S. applicants are required to complete one year of postgraduate training while FMGs are required to complete three years. This regulation was implemented by the Licensure Board to guarantee a standard of training for all Kentucky physicians and to assure competency by imposing U.S. training requirements. The Committee will continue to encourage active participation of FMGs in organized medicine through appointments to committees, election to offices, etc.

"Athletic Drug Problems"

The KMA Committee on School Health, Physical Education, and Medical Aspects of Sports has been actively involved in preparing and distributing to Kentucky's high school athletes a brochure entitled "Athletic Drug Problems." The brochure contains factual information on the effects of various drugs, particularly in the area of athletic performance.

More than 60,000 copies of the brochure have been distributed to Kentucky's athletes. KMA appreciates the assistance of the Kentucky High School Athletic Association and the Program Chairmen of the eight sports medicine seminars held during 1988 throughout the state in assisting with this distribution.

KMA is also grateful to Tyrone Jones, a student at the Shelby County High School, for his contribution of the cover art for the brochure.

Printing and distribution of the "Athletic Drug Problems" brochure have been funded entirely by outside contributions. KMA would like to acknowledge the generosity of those who have assisted financially in this project.

Boehringer-Ingelheim, Richfield, Connecticut, and Thomas W. Collins, representative, Pewee Valley

Central Baptist Hospital Sports Medicine Clinic, Lexington

Dista Products Company, a Division of Eli Lilly and Company, Indianapolis, Indiana, and Ross Weaver, representative, Paducah

Lederle Laboratories, a Division of American Cyanamid Company, and R. A. Geipil, Wayne, New Jersey

Eli Lilly and Company, Indianapolis, Indiana, and Arlyn F. Vedder, representative, Lexington

Marion Laboratories, Inc., Kansas City, Missouri, and William Hockensmith, representative, Prospect

Merck and Company, Inc., West Point, Pennsylvania

Merck Sharp & Dohme, and Charles Shannon, representative, West Point, Pennsylvania

A. H. Robins Company, Richmond, Virginia, and Steve Swift, representative, Owensboro

J. B. Roerig (Pfizer, Inc.) and Edward Hughes, representative, Doraville, Georgia

Searle Pharmaceuticals, Inc., and Dorothy R. Hunt, representative, Chicago, Illinois

Syntex Laboratories, Palo Alto, California, and Jeffrey Eadens, representative, Louisville

Trover Clinic, Madisonville

University of Louisville, Continuing Education/Sports Symposium, Louisville

Copies of "Athletic Drug Problems" may be obtained by contacting

KMA
3532 Ephraim McDowell Dr.
Louisville, KY 40205
(502) 459-9790

KENTUCKY MEDICAL ASSOCIATION
announces
TWO NEW PRACTICE MANAGEMENT WORKSHOPS
"For Members Only"

MEDICARE UPDATE 1988: How to do it Right!

Thursday, November 17, 1988
Hilton East Louisville
Half-day workshop

Presented by CONOMIKES ASSOCIATES

Are you keeping up with the new Medicare changes? Put an end to frustration and delays, loss of revenues and payments for you and your patients. Learn from specific examples how the new rules apply and how you can avoid costly errors. Enrollment is limited.
To register, call the KMA Office at (502) 459-9790.

TAX STRATEGIES FOR PHYSICIANS IN PRIVATE AND PART-TIME PRACTICE

Thursday , December 8, 1988
Holiday Inn Hurstbourne, Louisville
8:30 am - 3:30 pm

Presented by TAX REDUCTION INSTITUTE, Washington, D.C.

The complexity of the tax reform laws has impacted on the physician's practice and this course will deal with : Importance of Documentation, How to Maximize Deductions, How to Save Tax Dollars, IRS Audits - Reduce Your Chances , How to Handle if Selected.
Physician (and spouses) are encouraged to enroll.

For more information or to register, contact the KMA Office (502) 459-9790.

KMA 1988 Annual Meeting Highlights

The Kentucky Medical Association completed its Annual Meeting in Lexington on September 29. Over 1800 physicians and others registered for the meeting, which included two sessions of the KMA House of Delegates.

A record number attended the President's Luncheon, which highlighted the installation of Bob M. DeWeese, MD, Louisville, as the 1988-89 President of KMA. The Luncheon also featured the presentation of the Distinguished Service Award to Lexington internist Richard F. Hench, MD, for his efforts in the liability reform area, and the KMA Layman Award to Lieutenant Governor Brereton C. Jones for his accomplishments toward medical care for the indigent. Governor Jones was also the keynote speaker for the Luncheon.

The House of Delegates elected Nelson B. Rue, MD, Bowling Green general surgeon, as President-Elect. Doctor Rue will assume the office of President at the 1989 Annual Meeting. Russell L. Travis, MD, Lexington, was elected Vice President, with two new Trustees, John W. McClellan, MD, Henderson, and Charles T. Watson, MD, Ashland, being elected to the Second and Thirteenth KMA Districts, respectively. Wally O. Montgomery, MD, Paducah, and Kenneth P. Crawford, MD, Louisville, were elected as Delegates to the AMA, with Robert R. Goodin, MD, Louisville; Ardis D. Hoven, MD, Lexington; and Donald J. Swikert, MD, Florence, being elected as AMA Alternate Delegates.

Highlights of action by the House of Delegates included calling for changes in the state employees' health insurance contract to include, if necessary, encouraging the Governor to call a Special Session of the Kentucky General Assembly to address the problem; adoption of a Professional Liability Insurance Plan for 1988-89 to address the unresolved issues of importance to KMA; the appointment during the new Associational year of a task force to address the issue of affordable, high-quality obstetrical care for Kentuckians; continued endorsement of the Kentucky Physicians Care Program; addressing the problem of inappropriate requirements for hospital staff membership; support for the concept of tobacco-free schools; support of child car seat safety programs; and a study of the feasibility of expanding the KPC Program to include voluntary acceptance of Medicare assignment for the medically elderly.

The annual KEMPAC Dinner was also held during the Annual Meeting and was attended by many physicians and their spouses, as well as numerous members of the Kentucky General Assembly. Susan Bryant, political analyst from Washington, DC, was the featured speaker.

A full report of the Annual Meeting and actions by the House of Delegates will appear in the December issue of the KMA Journal.

CLASSIFIEDS

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All orders for classified advertising must be placed in writing and will be subject to approval by the Editorial Board. The right is reserved to decline or withdraw advertisements at the publisher's discretion.

Deadline: First day of month prior to month of publication.

Word count: Count as one word all single words, two initials of a name, single numbers or groups of numbers, hyphenated words, and abbreviations.

Rates to KMA members: $10 per insertion up to 50 words, 25¢ each additional word. To non-members: $30 per insertion up to 50 words, 25¢ each additional word.

Send advance payment with order to: The Journal of KMA, 3532 Ephraim McDowell Drive, Louisville, KY 40205.

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PRIMARY CARE PHYSICIAN OPPORTUNITY — Private and hospital practice in a beautiful community located in the center of the Cincinnati, Louisville, and Lexington triangle. Ideal place to raise a family. Guaranteed salary. Business management available. Inquiries to David Smith, MD, 114 North Madison Street, Owenton, Kentucky 40359. Ph. 502-484-2104.

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KMA
Physician Placement Service

Physician placement is another service offered by the Kentucky Medical Association. The Association acts as a clearinghouse by providing assistance to physicians seeking practice opportunities in Kentucky and to anyone who is searching for a physician.

A booklet entitled "Practice Opportunities in Kentucky" is published in January and July. We combined our services with those offered by the Kentucky Physician Placement Service, Cabinet for Human Resources, Frankfort, Kentucky. As a result, there is a substantial increase in the number of opportunities listed. If you have just completed your medical training or are interested in a change of location, you will find this booklet helpful.

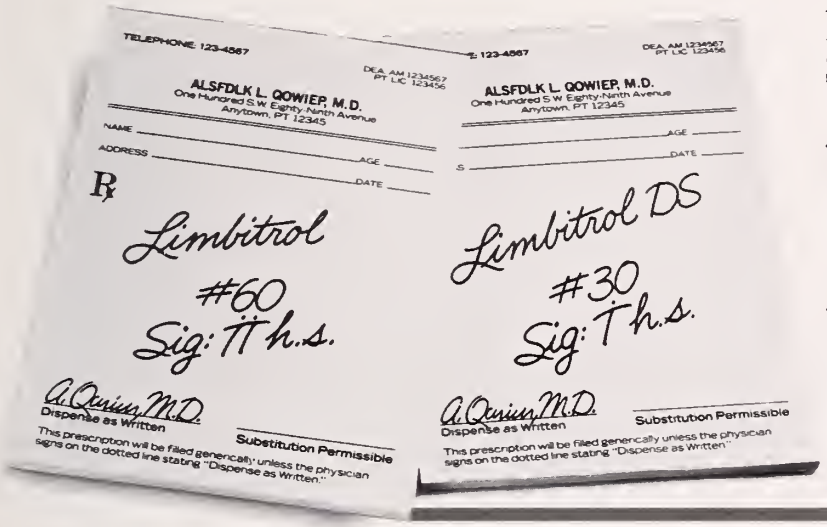
Kentucky Medical Association also publishes a "Physician Seeking" list which briefly outlines the background of the physician. This list is disseminated to communities, hospitals, clinics and physicians who are seeking the services of a physician.

If you are interested in these KMA services, please contact the:

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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

Limbitrol®Ⓥ
Tranquilizer—Antidepressant
Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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In the depressed and anxious patient

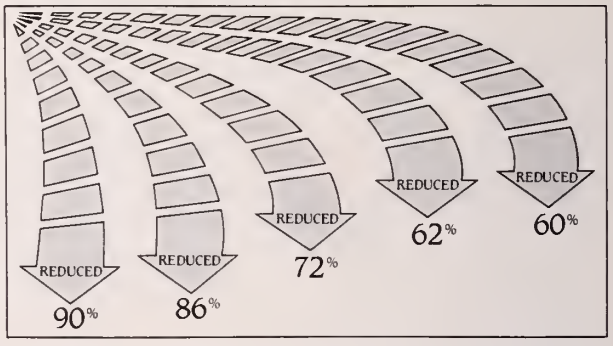
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- First-week reduction in somatic symptoms[1]

Caution patients about the combined effects of Limbitrol with alcohol or other CNS depressants and about activities requiring complete mental alertness, such as operating machinery or driving a car. In general, limit dosage to the lowest effective amount in elderly patients.

Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

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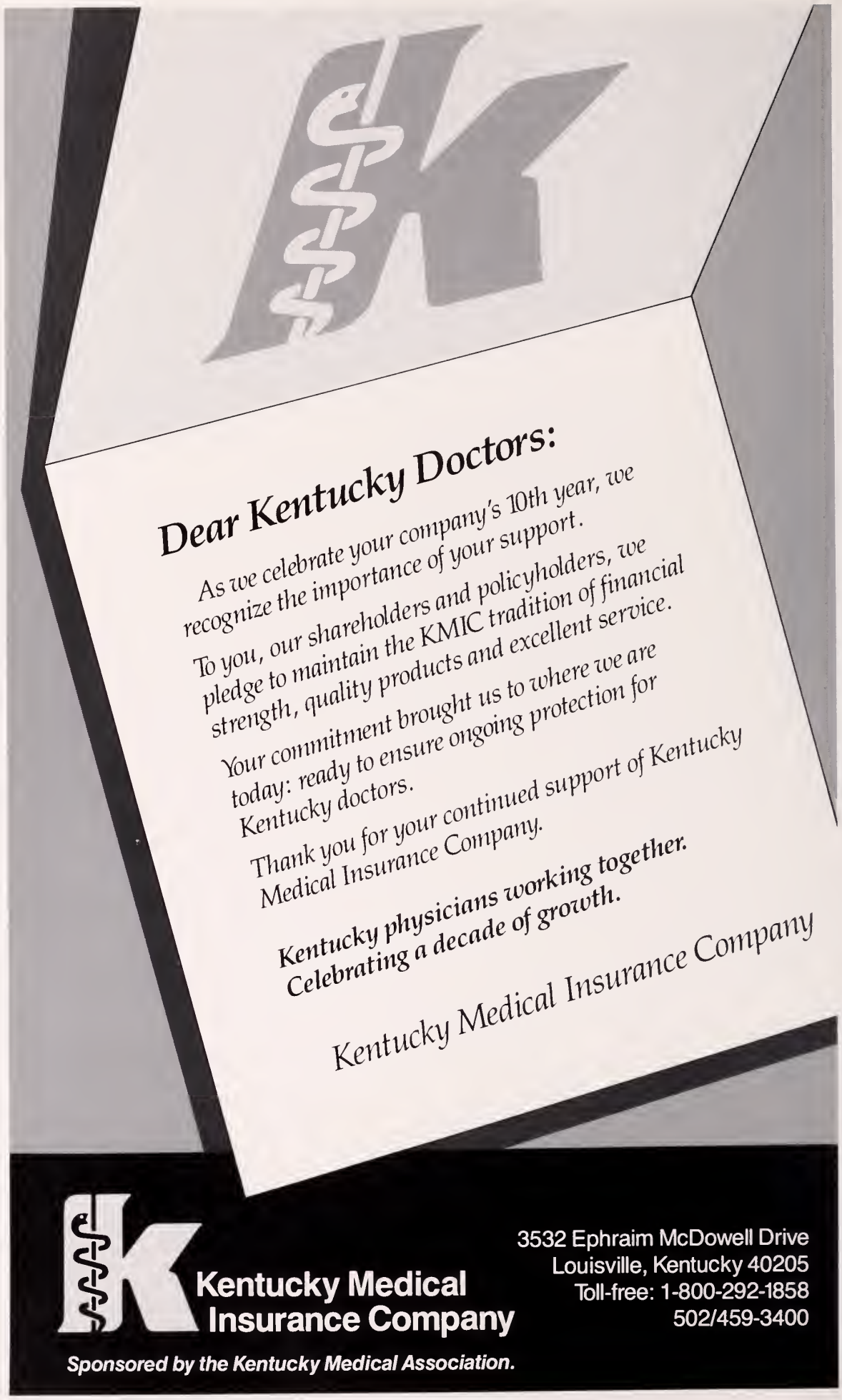

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TABLE OF

CONTENTS

December 1988

Cover:
Special thanks to the University of Louisville Health Sciences Center archives for furnishing the historical items pictured on this month's cover.
Linda Fortwengler, Designer
Jerry Duvall, Photographer

SCIENTIFIC

Life Threatening Asthma in Kentucky
Steven M. Smith, MD; D. Marty Denny, MD; Thomas M. Roy, MD 649

EDITORIAL

UCR 661

SPECIAL FEATURES

Deceased Kentucky Physicians 656
Poem 657
Delegate Roll Call 681
Digest of Proceedings, 1988 House of Delegates 685
Index of Proceedings 776
KMA Constitution & Bylaws 763
KMA Organization Chart 770
KMA Committees 771
KMA Reference Committees 684
Index to Volume 86 — 1988 779

ASSOCIATION

1988 KMA Annual Meeting 668
Carl Cooper, Jr, MD, Recognized by House of Delegates 676
Updates 676

REGULAR FEATURES

President's Page 647
Auxiliary 663
CME 778
Classified 777
Information for Authors 653

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DEC 1988

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KMIC....642
Kentucky Air National Guard....666
Eli Lilly & Company....678
Marketing Communication Resources....666
Medical Protective Company....667
MediGen of Kentucky....658
Miles Pharmaceuticals....659,660
Naval Reserve Force....664
PIE Mutual Insurance Company....662
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PRESIDENT'S PAGE



It seems almost impossible that year 1988 is near its end and that the most special Holiday Season of Christmastide is upon us. A feeling of merriment and goodwill is spreading to even the most hardened individuals and hearts seem to be a little lighter and minds a bit more reflective.

Every Christmas season brings certain favorite customs and traditions. No matter how many times we hear them, some of the familiar tales and stories are a necessary part of the holiday celebration. I am thinking of Dickens' *Christmas Carol*, a favorite of mine. You remember that classic character Scrooge who moves backward and forward in time to view his past, present, and future life and then, quite miraculously, wakes up from his dream and realizes that it is not too late to make amends for his past deeds.

I would like to draw an analogy for our profession to that of the miserly, inward-thinking Scrooge. He started out as an innocent lad who had high hopes and idealistic notions, but he became bitter, self-centered, and hardened. He saw only the ills of society and the wrongs that were so prevalent and he lost any desire to change them. Rather, he drew apart from his friends, his loved ones, his employees, and his own conscience. He was a miserable person.

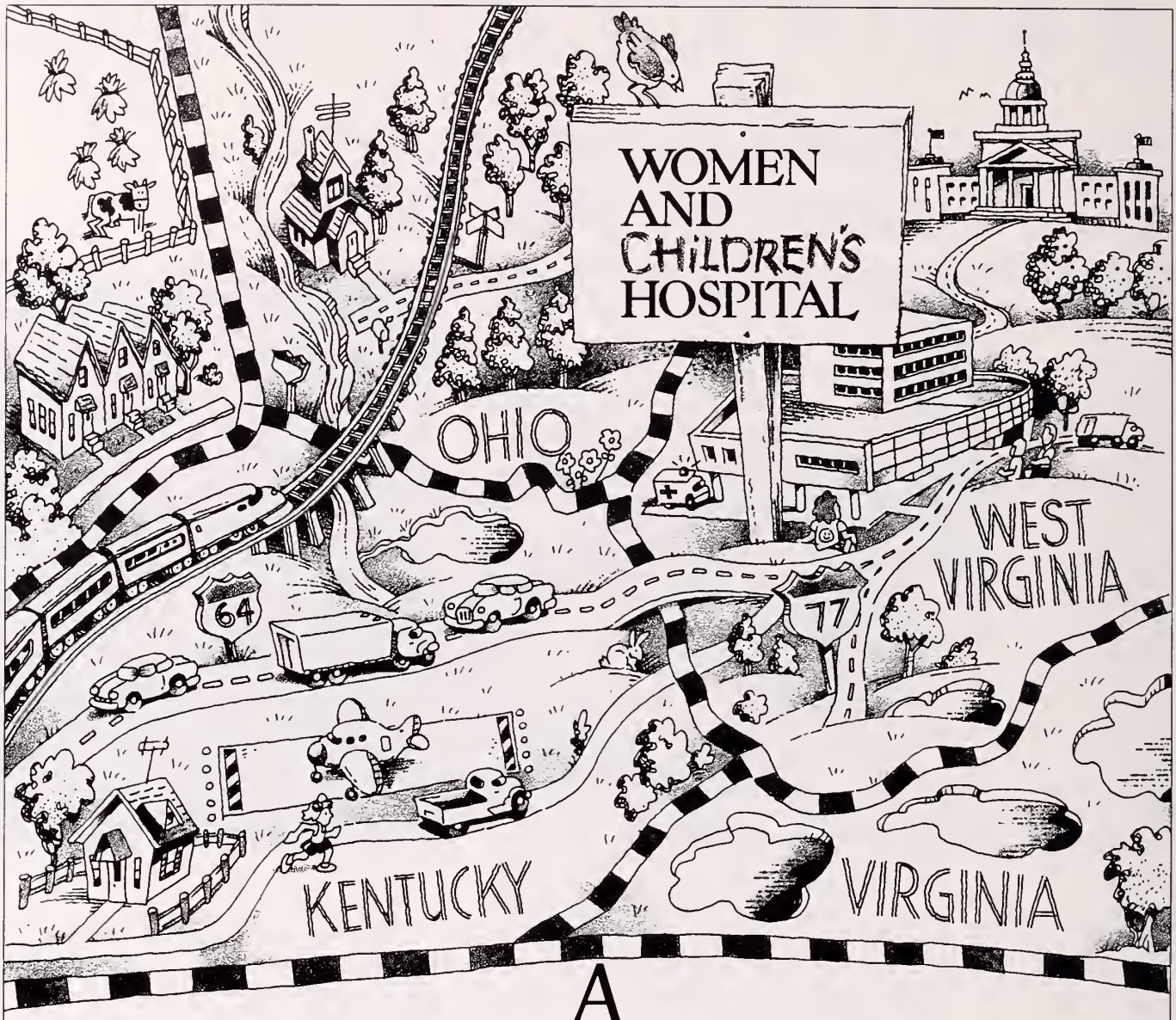
We doctors, like Scrooge, can look back to somewhat carefree days when most of us had high hopes, aspirations, and ideals for our medical profession. We had great opportunities to serve our patients and our communities and our fellowmen. Life got tougher for us and outside forces targeted our profession for many reasons. We squirmed and wiggled and fought our way around some unacceptable situations, but as long as they affected *OTHER* doctors and specialty groups, rather than the individual one of us, we tolerated things.

Like Scrooge, we did some inward thinking. With apathy and a "Fat Cat" attitude, we built walls around ourselves and our profession. We developed an air of complacency and assured our patients and our colleagues that the storms would blow over if we continued to practice quality medicine and do what we were trained to do without appearing to be self-serving. As time moved on, we realized that *EVERY* doctor and *EVERY* patient was being short-changed by the current medical trends and practices.

Like Scrooge, we can still influence our future. True, Scrooge had the luxury of awaking from a dream, and we have to deal with the reality of *NOW*. Our future will be bleak and empty if we do not seize the moment and take the time and energy to effect change in our profession. We *CAN* bring about the needed changes, you know, if we are willing to put aside individual interests and devote a few hours a day or week to working through our hospital groups and our own KMA to get our message across to our public community. This is my Christmas wish for our profession.

I hope that for the last several days of this December month, we doctors can take a recess from the weighty problems facing us and share some quiet and meaningful moments with our family and loved ones. From our house to your house, my family and I send you the warmest holiday greetings and the richest of blessings for the New Year.

Bob M. DeWeese, MD
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Life Threatening Asthma in Kentucky

From the Division of Respiratory and Environmental Medicine, University of Louisville School of Medicine, Louisville, Kentucky 40292 (Dr Smith).

Steven M. Smith, MD
D. Marty Denny, MD
Thomas M. Roy, MD

This study examines the profile and treatment of the asthmatic patient in Kentucky who required intensive care for life threatening asthma during the five-year period from 1983 to 1987, a time in which a national increase in asthma mortality was observed. In order to better understand the patient with potentially fatal asthma, we have contrasted our patient population with that described in the medical literature. Based on this review, we can make some recommendations that should help the practicing physicians of Kentucky to lower the state's annual asthma mortality which is presently 45 deaths each year.

Introduction

Compared with other causes of mortality, the number of deaths from asthma may be few in adults and rare in children, but in the case of such a potentially reversible disease, any death should be unacceptable. In the five-year period from 1979 to 1983, there was a national increase in asthma mortality from under 3,000 deaths per annum to approximately 3,500 deaths in 1983.[1] This increase in asthma mortality continues despite the availability of new effective bronchodilators and an increased emphasis on patient education efforts. Over the last five years, there have been 229 deaths due to asthma in the Commonwealth of Kentucky.[2]

The purpose of this report was to examine the profile of the asthmatic patient that required intensive care in our teaching hospital during the five-year span from 1983 to 1987. We then correlated outpatient and inpatient treatment factors with those prognostic indicators of fatal outcome from asthma that have been previously identified in the medical literature.

Methods

We reviewed the medical records of all patients admitted to the medical intensive care unit (MICU) of Humana Hospital University, a primary teaching hospital at the University of Louisville School of Medicine, during the period from June 1, 1983 to January 1, 1988. Patients were identified from the admission log books of the emergency room and the critical care units. In addition, the emergency room records were checked for possible patients with asthma related death who were treated but did not survive to be admitted. The medical records were audited for patient demographics which included age, sex, age at onset of asthma, and duration of the asthmatic episode that led to admission. The patient's outpatient treatment protocol and compliance were documented. It was determined if the patient had received medical treatment in the month prior to the intensive care admission, had a history of prior hospitalizations, or had a history of prior intubation or mechanical ventilation. We examined the treatment modalities in the emergency area with regard to the medications administered as well as any objective measurements to determine the severity of the attack. Results of arterial blood gas analysis, chest radiographs, complete blood counts with differentials, and sputum analysis were examined. It was determined if the patient was admitted directly to the intensive care unit or admitted first to another area of the hospital. If the latter occurred, we determined the time interval between admission and transfer to the critical care unit. Intensive care management was monitored to establish which medications were administered and whether intubation and mechanical ventilation were necessary. Finally, we determined the morbidity and mortality that occurred for this asthmatic subset with life threatening asthma.

Status asthmaticus for this study was defined as acute, severe wheezing that did not improve following four hours of aggressive administration of beta adrenergic agents and parenteral theophylline.

Results

During the period studied, 21 asthmatic patients generated 27 admissions to the MICU with the diagnosis of status asthmaticus. The mean age of the group was 39 years, with a range from 19 to 67 years. There were 19 females and two males in the study group. All but two individuals had been diagnosed as asthmatic at least ten years prior to the study, most since childhood. All patients in this study had records of prior hospitalization for asthma. Three patients had been intubated on prior admissions.

Eleven of the 27 hospitalizations were preceded by the patient seeking medical attention for worsening asthma. Most were seen in an emergency room or out-patient clinic within 24 hours of admission, with a range of 15 hours to

ten days. Six patients had been hospitalized and treated for exacerbation of asthma within the month prior to their intensive care admission.

All patients claimed to be compliant with their outpatient medications. Only one patient admitted to using over-the-counter medications such as Primatene Mist or tablets.

Twenty-three admissions involved patients on methylxanthines. The theophylline level was in the therapeutic range on 12 occasions, subtherapeutic in nine admissions, and in the toxic range on two admissions. For the total number of admissions, the patient had a therapeutic theophylline level at the time of presentation only 41% of the time (12/27).

On 19 of the 27 admissions, patients were using beta adrenergic metered dose inhalers. Additionally, on 11 of the 27 admissions, patients were on oral beta agonists. The number of admissions in which the patient was using both was ten. The number of admissions of patients not on beta adrenergics was seven.

Corticosteroids were being used as oral therapy at the time of ten of the 27 admissions, while in two other cases oral steroids had been weaned within the month prior to admission. One admission involved a patient who used a steroid metered dose inhaler rather than oral therapy.

In none of these admissions had the patient been on anticholinergic therapy or on chromolyn sodium.

Treatment in the emergency area involved titrated administration of parenteral aminophylline in those admissions with therapeutic or subtherapeutic levels. Inhaled beta adrenergic agents were administered by nebulization. Lack of improvement or deterioration of the patients status prompted admission to the Internal Medicine service. Interestingly, there was scant information on the medical record of any objective measurements made of the degree of severity of airflow obstruction other than vital signs. Chest radiographs were performed on all admissions, and all were consistent with hyperinflation. Only one chest film had evidence of an active infiltrate. In eight cases, the CBC reflected an elevated absolute eosinophil count.

Arterial blood gas analysis was performed on each admission with the patient on supplemental oxygen.

Twenty of the 27 intensive care admissions went directly to the critical care unit, six were initially admitted to the medical ward, and one admission was to the Transitional Care Unit. All seven admissions to the medical ward were transferred to the unit within 36 hours as their condition deteriorated.

Nine of the 27 admissions required intubation. Six of these were performed in the emergency room before admission to the intensive care unit. Three were intubated after admission. Interestingly, each of these three patients were from the seven cases initially admitted to areas other than the MICU. The mean duration of intubation and mechanical ventilation was 77.5 hours. The mean age of those requiring intubation was 42 years. Each episode of intubation involved a different individual. Two of the intubated patients had required intubation on an earlier admission. No barotrauma or untoward events occurred associated with intubation or mechanical ventilation.

Therapy after admission consisted of continued administration of theophylline parenterally (27/27), inhaled beta adrenergic therapy (26/27), subcutaneous terbutaline (4/27), parenteral corticosteroids (27/27), and inhaled anticholinergic therapy (18/27).

There was one asthma death. It occurred in a 67-year-old black female, a lifelong asthmatic, who was one of the patients that required intubation in the emergency room. She was also one of the two intubated patients in this series that had required intubation on an earlier admission. This death represents a five year mortality of 4% for this subgroup of asthmatics.

Discussion

Asthma, a disease recognized for more than 30 centuries, was recorded as a cause of death as far back as 1698.[1] Death from this potentially reversible disease should be preventable with close vigilance, and the mortality rate might be expected to decrease with the use of newer more effective bronchodilators. Unfortunately, in the 1960s there was an increase in asthma deaths in England, New Zealand, Australia, and to a lesser degree in the United States.[3] From 1979 to 1982, asthma deaths increased nationally from less than 3,000/year to 3,500/year.[4] This rise in asthma mortality has continued, involving both pediatric and adult age groups, with 3,800 deaths recorded in 1985.[5] In the period from 1983 to 1987, we have seen an average of 45 deaths from asthma each year in the Commonwealth of Kentucky (Table 1).

Most patients who ultimately die of asthma have a history that suggests deficiencies in management, with both the patient and physi-

cian sharing the blame. This *high risk* profile is a recurring theme in all major reviews of asthma deaths (Table 2).[5,6]

Asthma deaths usually occur in one of three clinical situations: (1) a sudden, severe attack with rather immediate demise; (2) a progressive and poorly treated attack with death occurring after ineffective treatment; or (3) an attack complicated by treatment mishaps. For discussion we will examine each situation separately, with the understanding that there is more commonly some clinical overlap.

In the first instance, the asthmatic patient has a sudden onset of a severe attack for which help is ineffective or unavailable. Death ensues quickly. Previous studies have shown that three-fourths of these unfortunate individuals die before receiving help from a physician or emergency unit. In fact, one-half of these subjects die before the call for assistance is made. Approximately one-fourth of these individuals who expire outside the hospital do so within 30 minutes of the onset of the fatal attack.[4,7] For those asthmatic patients in serious distress who die while receiving emergency treatment, the major problem appears to be an inability to effectively deliver medications due to mucus plugging and/or cardiovascular collapse.[8]

Investigators have noted a seasonal clustering of sudden asthma deaths to the winter months[9] and our series of intensive care admissions followed a similar clustering with 14/27 patients admitted between October and December. It has also been shown that patients dying suddenly are more likely to have recently been discharged from the hospital or emergency room[4,10], which is also demonstrated by the study group.

Aerosolized beta adrenergic bronchodilators have been the center of debate as a cause of sudden death in asthmatic patients since the 1960s. At this time, many physicians, especially in Great Britain, link the increase in asthma deaths to unsupervised aerosolized bronchodilator use.[11-13] While many studies have shown that patients often overuse their inhalers prior to their fatal attack, other countries, including the United States, had fairly stable rates of asthma deaths during the mid-1960s.[14] The relationship between the use of aerosolized bronchodilators and asthma deaths remains controversial. Other investigators site the major problem with aerosolized bronchodilators as due to a false sense of safety which delays the patient from seeking prompt medical attention.[5,14]

In the second situation, the asthmatic patient experiences a progressive attack, the severity of which is not fully appreciated by the patient, the physician, or both. Most often this occurs against a backdrop of poorly controlled asthma which has resulted either from nonaggressive therapy or noncompliance. It is of interest that 11/27 of our patients were seen and treated by a physician in the 24 hours prior to admission. If the eventual independent admission to the intensive care unit can be used as an indicator, we might safely state that these patients were treated ineffectively. We might also surmise that the severity of their attack may have gone unrecognized and emphasizes the need to perform some objective test of airflow in the asthmatic to compliment subjective impressions. The failure to measure peak expiratory flow rates or any other simple objective test of pulmonary function increases the risk of life threatening asthma three-fold.[5]

Another major prognostic factor for this group is an inadequate daily regimen of prescribed drug therapy. This is illustrated in our high risk study group (Table 3). It is clear that

TABLE I
Asthma Deaths in Kentucky

1983	45 Deaths
1984	43 Deaths
1985	49 Deaths
1986	45 Deaths
1987	47 Deaths
TOTAL	229 Deaths

MEAN = 45.8/Year

TABLE II
High-Risk Factors For Life Threatening Asthma

	Study Group
Asthmatic disease of long duration	25/29 86%
Previous admission with severe attack	29/29 100%
Prior intubation and mechanical ventilation	2/27 7%
Recent hospital admission (3 months)	6/27 22%
Recent emergency care	11/27 41%
Insufficient outpatient treatment	19/27 70%
Underuse of steroids	17/27 63%
Failure to obtain objective measurement of pulmonary function in last year	27/27 100%
Psychosocial depression or denial	? ?

therapy could have been more aggressive in most cases. Failure to use chromolyn sodium and anticholinergics in the outpatient management of this group can probably be explained by the fact that convenient therapy with these agents has only recently been introduced.

With regard to appropriate outpatient therapy, the tendency to undertreat with corticosteroids is recognized as a major contributor to death for this group which receives delayed or inadequate treatment.[3,15,16] Parenteral therapy with corticosteroids is now considered essential for the asthmatic patient that requires admission. Corticosteroids are also advised for the patient being discharged from the emergency area or office after a serious attack.[17]

It should be stressed that a number of patients who die in the hospital do so after periods of apparent subjective improvement. Most of these patients, however, continue with tachypnea and/or tachycardia and have poor objective measurements of airflow.[18] Other poor prognostic factors for the hospitalized asthmatic include concurrent respiratory infection, depression, and denial of the severity of their asthma.[3,19]

In the third situation, the asthmatic patient dies as a result of treatment interventions rather than from the delay of initiation of appropriate therapy. While this group is the smallest of the three, it also has the most direct link to the physician caring for the patient with life threatening disease. Examples of treatment mishaps include theophylline toxicity with seizures, unrecognized adrenal insufficiency, and inappropriate sedation. Toxic interactions between beta adrenergic drugs and theophylline have been examined and proposed as a mechanism of arrhythmias and death in this group, but there is no consensus on this point. Also of great concern is the welfare of the asthmatic who requires intubation and mechanical ventilation. This subgroup requires expert ventilator management to accomplish ventilation without barotrauma. The death rate for asthmatic patients who require mechanical ventilation ranges from 0.25% to 1.8%.[18,19]

Based on our review of the literature, several measures can be recommended to prevent potentially fatal asthma (Table 4).

In summary, we must acknowledge that most asthma deaths are potentially avoidable by optimum management. Although the asthma mortality figures for Kentucky have been relatively constant over the last five years, improvement in this area is needed. To accomplish this, physicians must first identify their high-risk asthmatic patients. Then, they must use objective measurements of airflow, the degree of pulsus paradoxus, and the deterioration of gas exchange to confirm their subjective impressions of the severity of an attack. Early aggressive treatment with corticosteroids is essential to avoid the need for mechanical ventilation. Finally close follow-up is crucial after discharge from the office, the emergency room, or the hospital after an episode of status asthmaticus.

TABLE III
Outpatient Treatment Of The Study Group

	Study	Group
Using methylxanthines	23/29	79%
Using inhaled beta-2 agents	19/27	70%
Using oral beta-2 agents	11/27	41%
Not using beta-2 agents, either form	7/27	26%
Using inhaled corticosteroids	1/27	4%
Using oral corticosteroids	10/27	37%
Using inhaled anticholinergics	0/27	0%
Using chromolyn sodium	0/27	0%

TABLE IV
Universally Recommended Measures to Reduce Life Threatening Asthma (5)

Provisions of an effective, simple drug regimen to enhance compliance
Provision of effective education for patient and family
Easy access to continuing and emergency medical care
Identification of the high-risk patient for more frequent follow-up
Monitoring the efficacy of therapy with objective measurements both when the patient is symptomatic and asymptomatic
Provision of a crisis plan for the high risk patient by which the patient or family can recognize worsening asthma and can initiate self-medication with corticosteroids as previously arranged between patients and physician

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- **For treatment of infections in the:**
  - **–lower respiratory tract†**
  - **–urinary tract†**
  - **–skin/skin structure†**
  - **–bones and joints†**
- **Convenient *B.I.D.* dosage – 250 mg, 500 mg and 750 mg tablets**

**In vitro* activity does not necessarily imply a correlation with *in vivo* results.
†**Due to susceptible strains of indicated pathogens. See indicated organisms in Brief Summary.**

CIPRO* SHOULD NOT BE USED IN CHILDREN, ADOLESCENTS, OR PREGNANT WOMEN.

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

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■ 500 mg q12h for most infections;
750 mg q12h for severe or complicated infections.

CIPRO®
(ciprofloxacin hydrochloride/Miles)
TABLETS

BRIEF SUMMARY
CONSULT PACKAGE INSERT FOR FULL PRESCRIBING INFORMATION

INDICATIONS AND USAGE

Cipro® is indicated for the treatment of infections caused by susceptible strains of the designated microorganisms in the conditions listed below

Lower Respiratory Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Pseudomonas aeruginosa, Haemophilus influenzae, Haemophilus parainfluenzae,* and *Streptococcus pneumoniae.*

Skin and Skin Structure Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Proteus mirabilis, Proteus vulgaris, Providencia stuartii, Morganella morganii, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus aureus* (penicillinase and nonpenicillinase-producing strains), *Staphylococcus epidermidis,* and *Streptococcus pyogenes*

Bone and Joint Infections caused by *Enterobacter cloacae, Serratia marcescens,* and *Pseudomonas aeruginosa*

Urinary Tract Infections caused by *Escherichia coli, Klebsiella pneumoniae, Enterobacter cloacae, Serratia marcescens, Proteus mirabilis, Providencia rettgeri, Morganella morganii, Citrobacter diversus, Citrobacter freundii, Pseudomonas aeruginosa, Staphylococcus epidermidis,* and *Streptococcus faecalis.*

Infectious Diarrhea caused by *Escherichia coli* (enterotoxigenic strains), *Campylobacter jejuni, Shigella flexneri,** and *Shigella sonnei** when antibacterial therapy is indicated

*Efficacy for this organism in this organ system was studied in fewer than 10 infections

Appropriate culture and susceptibility tests should be performed before treatment in order to isolate and identify organisms causing infection and to determine their susceptibility to ciprofloxacin. Therapy with Cipro® may be initiated before results of these tests are known; once results become available appropriate therapy should be continued. As with other drugs, some strains of *Pseudomonas aeruginosa* may develop resistance fairly rapidly during treatment with ciprofloxacin. Culture and susceptibility testing performed periodically during therapy will provide information not only on the therapeutic effect of the antimicrobial agent but also on the possible emergence of bacterial resistance.

CONTRAINDICATIONS

A history of hypersensitivity to ciprofloxacin is a contraindication to its use. A history of hypersensitivity to other quinolones may also contraindicate the use of ciprofloxacin.

WARNINGS

CIPROFLOXACIN SHOULD NOT BE USED IN CHILDREN, ADOLESCENTS, OR PREGNANT WOMEN. The oral administration of ciprofloxacin caused lameness in immature dogs. Histopathological examination of the weight-bearing joints of these dogs revealed permanent lesions of the cartilage. Related drugs such as nalidixic acid, cinoxacin, and norfloxacin also produced erosions of cartilage of weight-bearing joints and other signs of arthropathy in immature animals of various species (SEE ANIMAL PHARMACOLOGY SECTION IN FULL PRESCRIBING INFORMATION).

PRECAUTIONS

General: As with other quinolones, ciprofloxacin may cause central nervous system (CNS) stimulation, which may lead to tremor, restlessness, lightheadedness, confusion, and very rarely to hallucinations or convulsive seizures. Therefore, ciprofloxacin should be used with caution in patients with known or suspected CNS disorders, such as severe cerebral arteriosclerosis or epilepsy, or other factors which predispose to seizures (SEE ADVERSE REACTIONS).

Quinolones may also cause anaphylactic reactions and cardiovascular collapse. Anaphylactic reactions may require epinephrine and other emergency measures.

Crystals of ciprofloxacin have been observed rarely in the urine of human subjects but more frequently in the urine of laboratory animals. Crystalluria related to ciprofloxacin has been reported only rarely in man, because human urine is usually acidic. Patients receiving ciprofloxacin should be well hydrated, and alkalinity of the urine should be avoided. The recommended daily dose should not be exceeded. Alteration of the dosage regimen is necessary for patients with impairment of renal function (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

Drug Interactions: Concurrent administration of ciprofloxacin with theophylline may lead to elevated plasma concentrations of theophylline and prolongation of its elimination half-life. This may result in increased risk of theophylline-related adverse reactions. If concomitant use cannot be avoided, plasma levels of theophylline should be monitored and dosage adjustments made as appropriate.

Antacids containing magnesium hydroxide or aluminum hydroxide may interfere with the absorption of ciprofloxacin, resulting in serum and urine levels lower than desired; concurrent administration of these agents with ciprofloxacin should be avoided.

Probenecid interferes with the renal tubular secretion of ciprofloxacin and produces an increase in the level of ciprofloxacin in the serum. This should be considered if patients are receiving both drugs concomitantly.

As with other broad-spectrum antibiotics, prolonged use of ciprofloxacin may result in overgrowth of nonsusceptible organisms. Repeated evaluation of the patient's condition and microbial susceptibility testing is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Information for Patients: Patients should be advised that ciprofloxacin may be taken with or without meals. The preferred time of dosing is two hours after a meal. Patients should also be advised to drink fluids liberally and not take antacids containing magnesium or aluminum concomitantly or within two hours after dosing. Ciprofloxacin may cause dizziness or lightheadedness; therefore patients should know how they react to this drug before they operate an automobile or machinery or engage in activities requiring mental alertness or coordination.

Carcinogenesis, Mutagenesis, Impairment of Fertility: Eight *in vitro* mutagenicity tests have been conducted with ciprofloxacin and the test results are listed below:

- Salmonella/Microsome Test (Negative)
- *E coli* DNA Repair Assay (Negative)
- Mouse Lymphoma Cell Forward Mutation Assay (Positive)
- Chinese Hamster V_{79} Cell HGPRT Test (Negative)
- Syrian Hamster Embryo Cell Transformation Assay (Negative)
- *Saccharomyces cerevisiae* Point Mutation Assay (Negative)
- *Saccharomyces cerevisiae* Mitotic Crossover and Gene Conversion Assay (Negative)
- Rat Hepatocyte DNA Repair Assay (Positive)

Thus, two of the eight tests were positive, but the following three *in vivo* test systems gave negative results:

- Rat Hepatocyte DNA Repair Assay
- Micronucleus Test (Mice)
- Dominant Lethal Test (Mice)

Long-term carcinogenicity studies in animals have not yet been completed.

Pregnancy – Pregnancy Category C: Reproduction studies have been performed in rats and mice at doses up to six times the usual daily human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ciprofloxacin. In rabbits, as with most antimicrobial agents, ciprofloxacin (30 and 100 mg/kg orally) produced gastrointestinal disturbances resulting in maternal weight loss and an increased incidence of abortion. No teratogenicity was observed at either dose. After intravenous administration, at doses up to 20 mg/kg, no maternal toxicity was produced, and no embryotoxicity or teratogenicity was observed. There are, however, no adequate and well-controlled studies in pregnant women. SINCE CIPROFLOXACIN, LIKE OTHER DRUGS IN ITS CLASS, CAUSES ARTHROPATHY IN IMMATURE ANIMALS, IT SHOULD NOT BE USED IN PREGNANT WOMEN (SEE WARNINGS).

Nursing Mothers: It is not known whether ciprofloxacin is excreted in human milk; however, it is known that ciprofloxacin is excreted in the milk of lactating rats and that other drugs of this class are excreted in human milk. Because of this, and because of the potential for serious adverse reactions from ciprofloxacin in nursing infants, a decision should be made to discontinue nursing or to discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use: Ciprofloxacin should not be used in children because it causes arthropathy in immature animals (SEE WARNINGS).

ADVERSE REACTIONS

Ciprofloxacin is generally well tolerated. During clinical investigation, 2,799 patients received 2,868 courses of the drug. Adverse events that were considered likely to be drug related occurred in 7.3% of courses, possibly related in 9.2%, and remotely related in 3.0%. Ciprofloxacin was discontinued because of an adverse event in 3.5% of courses, primarily involving the gastrointestinal system (1.5%), skin (0.6%), and central nervous system (0.4%).

The most frequently reported events, drug related or not, were nausea (5.2%), diarrhea (2.3%), vomiting (2.0%), abdominal pain/discomfort (1.7%), headache (1.2%), restlessness (1.1%), and rash (1.1%).

Additional events that occurred in less than 1% of ciprofloxacin courses are listed below. Those typical of quinolones are italicized.

GASTROINTESTINAL: *(See above),* painful oral mucosa, oral candidiasis, dysphagia, intestinal perforation, gastrointestinal bleeding

CENTRAL NERVOUS SYSTEM *(See above), dizziness, lightheadedness, insomnia, nightmares, hallucinations, manic reaction, irritability, tremor, ataxia, convulsive seizures, lethargy, drowsiness, weakness, malaise, anorexia, phobia, depersonalization, depression, paresthesia*

SKIN/HYPERSENSITIVITY *(See above), pruritus, urticaria, photosensitivity, flushing, fever, chills, angioedema, edema of the face, neck, lips, conjunctivae or hands,* cutaneous candidiasis, hyperpigmentation, erythema nodosum

Allergic reactions ranging from urticaria to anaphylactic reactions have been reported.

SPECIAL SENSES: *blurred vision, disturbed vision, (change in color perception, overbrightness of lights), decreased visual acuity, diplopia, eye pain, tinnitus, bad taste.*

MUSCULOSKELETAL *joint or back pain, joint stiffness,* achiness, neck or chest pain, flare-up of gout.

RENAL/UROGENITAL *interstitial nephritis, renal failure,* polyuria, urinary retention, urethral bleeding, vaginitis, acidosis

CARDIOVASCULAR palpitations, atrial flutter, ventricular ectopy, syncope, hypertension, angina pectoris, myocardial infarction, cardiopulmonary arrest, cerebral thrombosis.

RESPIRATORY: epistaxis, laryngeal or pulmonary edema, hiccough, hemoptysis, dyspnea, bronchospasm, pulmonary embolism

Most of these events were described as only mild or moderate in severity, abated soon after the drug was discontinued, and required no treatment.

In several instances, nausea, vomiting, tremor, restlessness, agitation, or palpitations were judged by investigators to be related to elevated plasma levels of theophylline possibly as a result of a drug interaction with ciprofloxacin.

Adverse Laboratory Changes: Changes in laboratory parameters listed as adverse events without regard to drug relationship:

Hepatic – Elevations of: ALT (SGPT) (1.9%), AST (SGOT) (1.7%), alkaline phosphatase (0.8%), LDH (0.4%), serum bilirubin (0.3%).

Hematologic – eosinophilia (0.6%), leukopenia (0.4%), decreased blood platelets (0.1%), elevated blood platelets (0.1%), pancytopenia (0.1%).

Renal – Elevations of: Serum creatinine (1.1%), BUN (0.9%).

CRYSTALLURIA, CYLINDRURIA, AND HEMATURIA HAVE BEEN REPORTED.

Other changes occurring in less than 0.1% of courses were: Elevation of serum gammaglutamyl transferase, elevation of serum amylase, reduction in blood glucose, elevated uric acid, decrease in hemoglobin, anemia, bleeding diathesis, increase in blood monocytes, and leukocytosis.

OVERDOSAGE

Information on overdosage in humans is not available. In the event of acute overdosage, the stomach should be emptied by inducing vomiting or by gastric lavage. The patient should be carefully observed and given supportive treatment. Adequate hydration must be maintained. In the event of serious toxic reactions from overdosage, hemodialysis or peritoneal dialysis may aid in the removal of ciprofloxacin from the body, particularly if renal function is compromised.

DOSAGE AND ADMINISTRATION

The usual adult dosage for patients with urinary tract infections is 250 mg every 12 hours. For patients with complicated infections caused by organisms not highly susceptible, 500 mg may be administered every 12 hours.

Respiratory tract infections, skin and skin structure infections, and bone and joint infections may be treated with 500 mg every 12 hours. For more severe or complicated infections, a dosage of 750 mg may be given every 12 hours.

The recommended dosage for infectious diarrhea is 500 mg every 12 hours.

In patients with renal impairment, some modification of dosage is recommended (SEE DOSAGE AND ADMINISTRATION SECTION IN FULL PRESCRIBING INFORMATION).

HOW SUPPLIED

Cipro® (ciprofloxacin HCl/Miles) is available as tablets of 250 mg, 500 mg, and 750 mg in bottles of 50, and in Unit-Dose packages of 100 (SEE FULL PRESCRIBING INFORMATION FOR COMPLETE INFORMATION).

***Due to susceptible strains of indicated pathogens.**
See Indicated organisms in Prescribing Information.

CONVENIENT *B.I.D.* DOSAGE

Recommended dosage schedule

Infection Site*	Severity of Infection	Dosage
Respiratory Tract* Bone and Joint* Skin/Skin Structure*	Mild/Moderate	500 mg q12h
	Severe/Complicated	750 mg q12h
Urinary Tract*	Mild/Moderate	250 mg q12h
	Severe/Complicated	500 mg q12h
Infectious Diarrhea*	Mild/Moderate/Severe	500 mg q12h

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C09858A MLR-558

UCR

The changes in the economics of medical practice during recent years are bewildering. One of the most bewildering is the intense pressure now being applied to physicians to join with various health insurance programs to furnish medical and surgical care at fee schedules specified by the insurance companies. These programs have, until recently, had rather limited success. During the past year or two, however, their success has been much more impressive and, at present, a significant percentage of people in Kentucky have this type of health insurance. That percentage is presently increasing with great rapidity.

All this might be well and good were it not for the fact that the fee schedules for doctors under these plans are, for the most part, frightfully low. Many doctors have signed agreements as participating physicians with the understanding that the fee schedules would be based on the "usual, customary and reasonable" (UCR) concept. Some of the "plans" (one in particular) have managed to assemble an impressive list of participating physicians making their product (health insurance) very attractive to their customers in the world of business and industry who must purchase health insurance for their employees. The low fee schedules help make it possible to place an attractive low price on this type of health coverage and as a result of these two components, ie, big list of participating physicians plus low cost, this type of health insurance is "selling like hot cakes."

There is a lot of grumbling and discontent among participating physicians about the fee schedules. It turns out that most of these schedules are not usual, customary or reasonable according to present generally accepted interpretation of those terms. A few doctors have resigned as participating physicians, but most have not. The dilemma all this puts us doctors in is a difficult one. If, as a matter of principle, we refuse to participate, we automatically lose a lot of our patients. If, on the other hand, we continue to support this sort of thing, these particular insurance outfits will soon become the major health insurance providers in this area and will be in a position to pretty well control what doctors get paid. There should, at this stage of the game, be some sort of formal, organized communication between the groups of "participating physicians" and the insurance companies so that a mutually agreeable and fairer way of determining fees could be established. In the long run, this would, I believe, benefit both parties.

One final word about doctors' fees. We all know that the cost of medical care has skyrocketed in the past 10 to 20 years way out of proportion to the general overall increase in the price index. This disproportionate increase has been due for the most part to hospitalization costs and to the cost of expensive new technologies but not to doctors' fees. Doctors' fee increases in Kentucky have not been significantly out of proportion to the general inflation. I recently came across a bill of my mother's hospitalization in 1927 when she had a thyroidectomy for a toxic goiter (Fig 1). Note that the total hospital bill for one week with major surgery and private duty nurses was $65.00. The bill today would probably be 60 times that or more (Fig 2). I doubt that the doctor's fee for thyroidectomy in 1988 has increased more, percentage wise, since 1927 than the average costs of goods and services.

McHenry S. Brewer, MD

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Fig 1.

Hospital Charges 1988 (Louisville)

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OR (1st hour)	$600-$933
each additional ½ hour	$264-$466

Fig 2.



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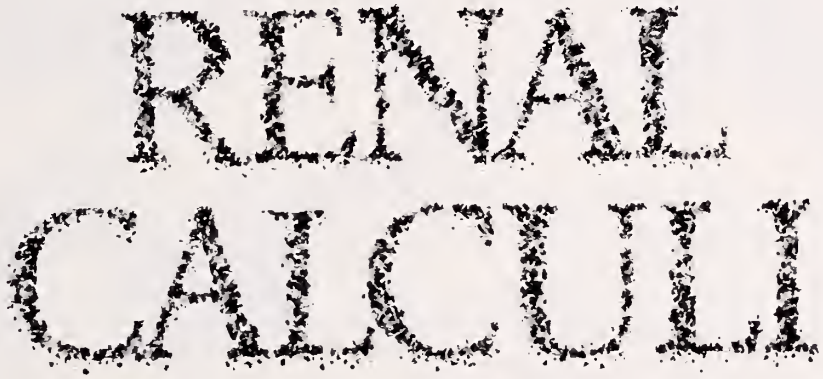
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As you can imagine, Lithotripsy offers many benefits to kidney stone patients. The process is less painful, entails fewer side effects, and recuperation is quicker than with conventional surgery. It's even less expensive than surgery.

We're encouraging all area urologists to apply for privileges in Extracorporeal Shock Wave Lithotripsy. We invite you to visit CAMC and see the lithotripter in action. Come and learn about this revolutionary therapy. We will happily provide you with a brochure for your use as well as brochures for your patients.

For your brochures or other information about Lithotripsy and our kidney stone treatment program, call CAMC: in West Virginia at 1-800-654-0159; from out of state, call 304-340-7315.

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1988 KMA Annual Meeting

Elections

Nelson B. Rue, MD, a Bowling Green general surgeon, was elected to the office of President-Elect of KMA during the 138th AnnuaI Meeting of the KMA House of Delegates. Doctor Rue, a graduate of the University of Louisville School of Medicine, served KMA as Trustee of the 6th District from 1981-1987, Chairman of the Board of Trustees 1984-1987, and Vice President in 1988.

Russell L. Travis, MD, a neurosurgeon from Lexington and former AMA Delegate, was elected to the office of Vice President.

Wally O. Montgomery, MD, a Paducah general surgeon, was elected KMA Delegate to the AMA, and Kenneth P. Crawford, MD, a pediatrician from Louisville, was reelected Delegate.

Louisville cardiologist Robert R. Goodin, MD, was reelected Alternate Delegate to the AMA, and Donald J. Swikert, MD, a Florence family physician, and Ardis D. Hoven, MD, a Lexington internist, were elected as Alternate Delegates to the AMA.

In other elections, the KMA House of Delegates elected Charles T. Watson, MD, Ashland, 13th District Trustee, and John W. McClellan, Jr, MD, Second District Trustee. Re-elected to three-year terms by the House were Cecil D. Martin, MD, Carrollton, Seventh District Trustee; William B. Monnig, MD, Edgewood, Eighth District Trustee; Kelly G. Moss, MD, Maysville, Ninth District Trustee; and Preston P. Nunnelley, MD, Lexington, Tenth District Trustee.

Board of Trustees elections included the reelection of William B. Monnig, MD, Edgewood, as Chairman of the KMA Board of Trustees, and the election of Preston P. Nunnelley, MD, Lexington, as Vice Chairman of the Board. John D. Noonan, MD, a Paducah neurosurgeon, and Emanuel H. Rader, MD, a Pineville family physician, joined the KMA Executive Committee.

President's Luncheon

A record crowd at the President's Luncheon honored outgoing President Donald C. Barton, MD, and participated in the installation of Bob M. DeWeese, MD, as the 138th President of KMA. They also witnessed the awarding of the Association's highest honor, the KMA Distinguished Service Award, to Richard F. Hench, MD, a Lexington internist. Doctor Hench was honored for his commitment to his patients and





President-Elect Nelson B. Rue, MD, and his wife, Sue, are escorted to the podium by Wally O. Montgomery, MD, Paducah (L), and Paul J. Parks, MD, Bowling Green (R).



The Honorable Lieutenant Governor Brereton C. Jones, is pictured with newly installed President Bob M. DeWeese, MD, Louisville (center), and Immediate Past President Donald C. Barton, MD, Corbin (R).



Left to Right: S. Randolph Scheen, MD, Louisville, Secretary-Treasurer; Bob M. DeWeese, MD, Louisville, President; Nelson B. Rue, MD, Bowling Green, President-Elect; and William B. Monnig, MD, Edgewood, Chairman, Board of Trustees.



Lieutenant Governor Brereton C. Jones was the guest speaker for the President's Luncheon.

the public, and for his loyalty to his profession which has been exhibited through his intense and unselfish devotion to resolving one of society's critical problems — the escalating liability crisis. His famous "One-Slide Slide Show," pointing out that only 38 cents of the premium dollar reached the injured patient, became Doctor Hench's trademark as he traveled throughout the state appearing before legislative, business, and civic symposiums outlining the dilemma in which physicians had been placed and seeking support for reform of the legal system, while at the same time managing to efficiently and effectively negotiate his duties as President of the KMA.

Included in Doctor Hench's past service to KMA are positions as Trustee, Vice President, Vice Chairman, two-term Chairman of the KMA Board of Trustees, as well as service on numerous committees.

The Honorable Brereton C. Jones, Lieutenant Governor of Kentucky, was the recipient of the KMA R. Haynes Barr Award which the House of Delegates authorizes for presentation to a layperson who has distinguished him or herself in the field of health. As a result of his concern for his constituents without healthcare coverage and without any means of support, Governor Jones formed a unique coalition with the Kentucky Medical Association, the Kentucky Hospital Association and the Kentucky Department of Human Resources whereby Kentuckians unable to afford medical care were matched with physicians and hospitals in the patient's community who volunteered to provide healthcare free of charge. This unique coalition between government, private sector, and healthcare providers is unmatched anywhere in the United States. The program has been honored throughout the U.S. and is a role model for other states searching for a program to provide medical care for people unable to care for themselves.

Governor Jones did not restrict his healthcare agenda exclusively to this program. He played a major role in raising $22 million for cancer research, and sponsored a one-night endowment event which raised $3.2 million for the McDowell Cancer Research Foundation.

In addition, Brereton Jones has been aware of the need to improve Kentucky education. He addressed this extensively as guest speaker at the President's Luncheon, with particular emphasis on the fact that the Commonwealth cannot solve the healthcare crisis until the educational crisis is solved. A few of his observations were, "The cost of education is the key to poverty. The schools build the community and contrary to what some would have us believe, the average Kentuckian is willing to invest in the future through support of education. We all have to be just as concerned with the educational system as we are with health care. We will never have enough money to support the healthcare of our citizens, so we must educate them so

they can become self-supporting. We need to develop a game plan. I am dedicated to improving what the KMA stands for in health care. I have respect for each of you. We must do everything we can to adequately fund health care in the state. I look forward to working with you on this."

House of Delegates

During the first meeting of the House of Delegates on September 26, Pamela Potter, AKMA Past President, presented AMA/ERF checks to the two medical schools on behalf of the Auxiliary. Through a cooperative effort by American medicine, private enterprise, and the dedicated fund raising efforts of auxilians throughout the country, funds are provided in support of medical education, financial assistance to medical students, scientific and medical research, and rural and community-oriented pilot health projects. In Kentucky, the funds are given proportionally as designated by the donors to the two medical schools. A check for $16,657.39 was presented to the University of Kentucky College of Medicine, and $24,565.35 was presented to the University of Louisville School of Medicine.

This year the recipient of the KMA Educational Achievement Award was William P. VonderHaar, MD, of Louisville. Doctor VonderHaar achieved distinction for his achievements in promoting and furthering the quality of family practice education, serving as the First Chairman of the Department of Family Practice at the University of Louisville. He served as Associate Professor in the Department of Family Practice at the University from 1972-1974; as a full professor in 1974; as an associate in psychiatry from 1975-1981; and currently serves as a clinical professor. Doctor VonderHaar has served in many civic capacities and the list of his numerous activities on behalf of medicine





TOP PHOTO: Chairman of the Board, William B. Monnig, MD, administers the Presidential Oath-of-Office to Bob M. DeWeese, MD. CENTER: Richard F. Hench, MD, was the recipient of the KMA Distinguished Service Award for his commitment and loyalty to his profession. Presenting the award is S. Randolph Scheen, MD, Chairman of the Awards Committee (L). BOTTOM RIGHT: David L. Stewart, MD, Louisville (L), received an award for his role in establishing the KMA Impaired Physicians Committee. Immediate Past President Donald C. Barton made the presentation.



Peter C. Campbell, MD, Louisville, Speaker, House of Delegates.

















Clockwise from top center: S. Randolph Scheen, MD, presented the KMA R. Haynes Barr Award to Brereton C. Jones, Lieutenant Governor of Kentucky; Dr. David Weigman, Vice Chairman for Academic Affairs at U of L, expressed his appreciation for the Auxiliary's AMA-ERF check; Pamela Potter, Past President of the AKMA, presented an AMA-ERF check to Emery A. Wilson, MD, Dean of the U of K College of Medicine; Vice Speaker Danny M. Clark, MD, Somerset (L), is pictured with Chairman Monnig and Past President Barton (R); AMA Delegate Fred C. Rainey, MD, Elizabethtown; John MacDougall, MD, President of the Indiana State Medical Association, with Kentucky's President DeWeese; William P. VonderHaar, MD, Louisville, recipient of the KMA Educational Achievement Award.

and patients is extensive.

In addition to these awards, the House of Delegates commended the following:

- David L. Stewart, MD, Louisville, for his role in establishing the KMA Impaired Physicians Committee, and his humanitarian efforts over the years which have brought great credit to the medical community.
- Wally O. Montgomery, MD, and the State Legislative Committee for their 1988 General Assembly activity.
- John Petry, MD, for his efforts on behalf of maternal mortality studies.
- Thomas M. Marshall, MD, for his many years of service as Co-Chairman of the Physician-Attorney Liaison Committee.
- Carl L. Wedekind, Jr, for his role in liability insurance reform.

Also recognized:

- Carl Cooper, Jr, MD, retiring AMA Alternate Delegate, for his service to KMA.

Thanked retiring Trustees:

- Albert H. Joslin, MD, Owensboro
- Jerald M. Ford, MD, Ashland

Five physicians were elected by the House of Delegates to serve on the 1989 Nominating Committee. Members elected were:

Ronald E. Waldridge, MD, Shelbyville, Chairman
Ralph L. Cash, MD, Princeton
Gregory J. Sherry, MD, Somerset
Bruce M. Stapleton, MD, Ashland
Gary R. Wallace, MD, Lexington

Reports of the KMA Committees and Resolutions were introduced during the first House of Delegates meeting. During the second meeting the House considered 32 Resolutions and 43 Reports.

Major actions of the House were:

1. Urged changes in State Employee Health Care Plan.
   - — Under the present system, the State employee health insurance contract offers few alternatives to state employees and teachers in 66 counties. In those 66 counties enrollees would have a deductible of $400 individual and $800 family, with a maximum out-of-pocket expense of $1,500 individual and $3,500 for family coverage.
   - — The House voted to support the position of state employees and teachers, to include the state employee health insurance contract in any future special session of the Kentucky General Assembly. A press release was mailed October 4 outlining KMA's objections and urging immediate action.
   - — In a Resolution, the KMA House of Delegates expressed concern that Kentucky Kare may "directly affect the survival and financial viability of rural hospitals and adversely impact the continuity or access to medical care" for state employees, their families, and other members of rural communities.
   - — The KMA's Delegates wrote in their Resolution that, "the practical effect of the high deductibles is to make participation in managed care plans the only financially feasible alternative, thereby limiting



Harold L. Bushey, MD, Barbourville (R), received the KEMPAC Past Chairman's gavel from Sam D. Weakley, MD, Louisville, KEMPAC Chairman.



Nelson B. Rue, MD, Bowling Green (L), is seated with Albert H. Joslin, MD, Owensboro, retiring Trustee from the 2nd District.



L to R: William P. VonderHaar, Lolita S. Weakley, and Sam D. Weakley, Jefferson; Gordon W. Air, Fred A. Stine, and Charles F. Allnutt, Campbell-Kenton.



L to R from Fayette County: John R. Allen, Thomas K. Slabaugh, Ardis D. Hoven, Thomas M. Jarboe, and Harold T. Faulconer.



L to R: William H. Klompus and Charles R. Dodds, Hopkins; Emmanuel J. Battah and Irene Y. Villarosa, Christian; N. H. Talley, Caldwell; Delmas M. Clardy, Christian.



L to R from Fayette County: John E. Trevey, William D. Medina, E. C. Seeley, John W. Collins, William R. Meeker, Jr., John R. Allen, and Thomas K. Slabaugh.

freedom of choice for employees." A copy of the Resolution and a letter were mailed to all state employee groups, the Kentucky Education Association, and other associated state employee organizations.

2. Adopted a 1988-89 Professional Liability Insurance Plan to pursue additional liability reform. The Plan includes activities to be carried out by the Association during the interim and special legislative proposals for the 1990 Kentucky General Assembly. Those proposals include:
   — Alter or eliminate Section 54 of the Constitution which presently prohibits caps on awards.
   — Permit structured settlements in lieu of lump sum payments.
   — Reduce the statute of limitations for minors.
   — Reform the present fault-based system of medical liability to a no-fault plan or program similar to the Workers' Compensation system.

Other liability report measures recommended include legislation relating to neurologically impaired newborns. The House of Delegates also urged KMA to work with other professional organizations and support legislation to protect personal assets, retirement funds, and homes from claims in professional liability awards.

Summary of other House action:

- Continue the Kentucky Physicians Care Program through December 31, 1989; however, the Program should be reevaluated in view of continuing delivery of high quality care for long-term illnesses.
- Basic KMA dues structure remained; however, the House of Delegates approved reallocation of PLI funds whereby $375 goes to the general fund and $25 to the PLI Reform Plan.
- Opposed inappropriate liability insurance requirements for hospital staff membership.
- Questioned the hiring of medical school faculty for private practice and asked the Board of Trustees to



AKMA Past President Pamela Potter presented AMA-ERF awards to Eloise Meigs, Ashland (L), and Pam Blackstone, Owensboro, (center).



Newly elected President DeWeese and his wife, Angie, had a very exciting Inauguration Day.

investigate and report on the activities of medical school faculty members and their role in fulfilling the educational mission of medical schools in Kentucky.

- Urged stronger enforcement of DUI laws.
- Supported a study to determine ways to increase availability of obstetrical services.
- Recommended that legislation be introduced requiring stores that sell alcoholic beverages to post signs warning against the use of alcoholic beverages during pregnancy.
- Supported establishment of a statewide head injury registry and urged physicians to participate.
- Opposed liability insurance carriers influencing the practice of medicine.
- Supported nursing education and improved conditions to attract and maintain an adequate supply of nurses.
- Directed that guidelines be developed to identify minimum patient coverages that any managed health care program or insurance plan should have.
- Recommended that all physicians and county medical societies become involved in implementation of mandatory sex education programs and participate in local committees designated to establish parent and family life skills in public schools.
- Recommended additional study of the proposal to expand the Kentucky Physicians Care Program to include Medicare assignment for needy elderly patients.
- Recommended support for the concept of tobacco-free schools.
- Encouraged county medical societies to develop child car seat safety programs.
- Urged state authorities to enforce laboratory regulations.
- Encouraged the Secretary for Human Resources to provide reimbursement for Medicaid and Ken-PAC patients, at cost plus administrative fee, for child immunizations.
- Supported Kentucky Infectious Waste Task Force's attempt to govern disposal of medical waste materials.
- Urged members to pursue knowledge and data regarding AIDS so that HIV positive patients can be properly counseled or referred to appropriate specialists or government agencies for counseling.
- Reaffirmed previous policy that local health departments should continue to fulfill their traditional public health mission; but opposed proposed plans of CHR to provide unrestricted medical services through local health departments.
- Suggested to appropriate government and nursing home officials that cooperative efforts with hospitals and physicians should be made to expedite transfer of patients.
- Encouraged residency programs to provide ACLS and BCLS certification for all residents.
- Opposed arbitrary limitation on number of inpatient hospital days a patient receives postpartum care.
- Encouraged physicians to complete the U.S. standard birth certificate in its entirety.

Attendance

A total of 1,886 people registered, including 989 physicians, for a very successful 138th KMA Annual Meeting at the Hyatt Regency in Lexington. The 1989 meeting will be held September 17-21 at the Hurstbourne Hotel and Convention Center (formerly the Ramada Inn) in Louisville.

Carl Cooper, Jr, MD Recognized by the KMA House of Delegates

Carl Cooper, Jr, MD, of Bedford, was recognized at the final session of the House of Delegates for his many years of service. Doctor Cooper, a past President of KMA, former Speaker of the House, and recipient of the Distinguished Service Award, chose not to seek reelection as AMA Alternate Delegate. Doctor Cooper has served on the Board of Trustees for over 20 years and was Chairman of the KMA Committee on State Legislative Activities for 11 years.



Updates

Doctor Polk Honored With Leadership Role

Hiram C. Polk, Jr, MD, of Louisville, has been elected President of the Southern Surgical Association. Dr Polk is Chairman of the Department of Surgery at the University of Louisville.

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For respiratory tract infections due to susceptible strains of indicated organisms.

Summary.
Consult the package literature for prescribing information.

Indication: Lower respiratory infections, including pneumonia, caused by *Streptococcus pneumoniae, Haemophilus influenzae,* and *Streptococcus pyogenes* (group A β-hemolytic streptococci).
Contraindication: Known allergy to cephalosporins
Warnings: CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis

Precautions:
- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- Ceclor should be administered with caution in the presence of markedly impaired renal function. Although dosage adjustments in moderate to severe renal impairment are usually not required, careful clinical observation and laboratory studies should be made
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor penetrates mother's milk. Exercise caution in prescribing for these patients.

Adverse Reactions: (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:
- Gastrointestinal (mostly diarrhea): 2.5%
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, and serum-sickness-like reactions that have included erythema multiforme [rarely, Stevens-Johnson syndrome] and toxic epidermal necrolysis or the above skin manifestations accompanied by arthritis/arthralgia, and frequently, fever): 1.5%, usually subside within a few days after cessation of therapy. Serum-sickness-like reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome
- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- As with some penicillins and some other cephalosporins, transient hepatitis and cholestatic jaundice have been reported rarely
- Rarely, reversible hyperactivity, nervousness, insomnia, confusion, hypertonia, dizziness, and somnolence have been reported
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%, and, rarely, thrombocytopenia

Abnormalities in laboratory results of uncertain etiology
- Slight elevations in hepatic enzymes
- Transient fluctuations in leukocyte count (especially in infants and children).
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test.
- False-positive tests for urinary glucose with Benedicts or Fehlings solution and Clinitest® tablets but not with Tes-Tape® (glucose enzymatic test strip, Lilly).

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Soldier being examined for effects of high-altitude cerebral edema.

ALLAN J. HAMILTON, M.D.

Neurosurgical Resident and Research Fellow, Massachusetts General Hospital, Boston, Massachusetts. Captain, U.S. Army Reserve.

EDUCATION Ithaca College, B.A. (Magna Cum Laude); Hamilton College (Pre-med); Harvard Medical School.

RESIDENCY General Surgical Internship. Neurosurgical Residency, Massachusetts General Hospital.

CONTINUING EDUCATION Neurology and Neurosurgery Research Fellowship Training, National Institutes of Health.

OUTSTANDING ACHIEVEMENTS Olsen Memorial Fellowship, National Masonic Medical Research Foundation; Albert Schweitzer Fellowship, International Albert Schweitzer Foundation; Harvard Medical School Cabot Prize for Best Senior Thesis; recently published article, "Who Shall Live and Who Shall Die" in Newsweek Magazine.

"The work I'm doing in the Army Reserve fits perfectly with my academic research interests in civilian life. The Army is very concerned with the effects of high-altitude cerebral edema, which is a mirror model of cerebral hypoxia, something I deal with every day in our neurosurgical intensive care unit. I couldn't ask for a smoother transition. And that's true for a lot of Reserve physicians. All we really do is change our clothes, not our mindset.

"Some of the projects the Army is undertaking are on the cutting edge of research. For example, I'm currently involved in developing for the Army a prototype of a non-invasive intracranial pressure-monitoring device that we hope will allow us to measure pressure changes as the brain swells—without drilling holes in the skull. If we can get our design to work, such a device could revolutionize high-altitude medicine as well as civilian neurosurgical care.

"The quality of medicine and the caliber of people I've been associated with in the Army Reserve are, without question, equal to civilian hospitals. In fact, I'm giving serious consideration to applying for an active duty academic position in Army Medicine when my residency ends at Massachusetts General."

Find out more about the medical opportunities in the Army Reserve. Call toll free 1-800-USA-ARMY.

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Letters

September 28, 1988

Donald C. Barton, MD
President, Kentucky Medical Association
3532 Ephraim McDowell Drive
Louisville, KY 40205

Dear Doctor Barton:

Thank you very much for the opportunity to be a participant in the 138th Annual Meeting of the Kentucky Medical Association. I enjoyed my visit to Lexington and very much appreciate your hospitality and generosity.

Sincerely,
C. Robert Stanhope, MD
Gynecologic Surgery
Mayo Clinic

October 6, 1988

Robert G. Cox
Executive Vice-President
Kentucky Medical Association
3532 Ephraim McDowell Drive
Louisville, KY 40205

Dear Mr. Cox:

I wanted to send you a note to tell you how much my wife and I appreciated your hospitality as we visited with your members at the recent Kentucky Medical Association meeting held in Lexington. We felt right at home! You ran a splendid meeting and we were impressed.

Thanks again for your invitation and that warm Southern hospitality.

Sincerely yours,
William J. Marshall, MD, FACP, FACC
President-Elect
Ohio State Medical Association

October 10, 1988

Bob M. DeWeese, MD, President
Kentucky Medical Association
3532 Ephraim McDowell Drive
Louisville, KY 40205

Dear Bob:

My wife, Carolyn, and I wish to thank the Kentucky Medical Association for the opportunity to attend your annual meeting this year. It was a very rewarding and educational experience for the both of us. We wish also to express our thanks to our gracious hosts, Nelson and Sue Rue.

Sincerely,
Bill M. Atkinson, MD
President
West Virginia State Medical Association

October 18, 1988

William Applegate
3532 Ephraim McDowell Drive
Louisville, KY 40205

Dear Mr. Applegate:

I certainly enjoyed my visit to the annual meeting of the Kentucky Medical Association. This was a very well arranged and conducted meeting. I met many friends and made some new ones. I am really thankful to the organizing committee for this opportunity.

With best personal regards,
Bashir A. Chaudhary, MD
Professor of Medicine
Section of Pulmonary Diseases
Department of Medicine
Medical College of Georgia

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Was Your Delegate Present?
ROLL CALL
1988 House of Delegates
KMA Annual Meeting

OFFICERS

		First Meeting	Second Meeting
Speaker	Peter C. Campbell, Jr.	Present	Present
Vice Speaker	Danny M. Clark	Present	Present
President	Donald C. Barton	Present	Present
President-Elect	Bob M. DeWeese	Present	Present
Vice-President	Nelson B. Rue	Present	Present
Secretary-Treasurer	S. Randolph Scheen	Present	Present
Delegate to the AMA	Fred C. Rainey	Present	Present
Delegate to the AMA	Donald C. Barton	Present	Present
Delegate to the AMA	Kenneth P. Crawford	Present	Present
Delegate to the AMA	Russell L. Travis	.....	.....
Alternate Delegate to the AMA	Robert R. Goodin	.....	Present
Alternate Delegate to the AMA	Wally O. Montgomery	Present	Present
Alternate Delegate to the AMA	Harold L. Bushey	Present	Present
Alternate Delegate to the AMA	Carl Cooper, Jr.	Present	Present

TRUSTEES

District			
First	John D. Noonan	Present	Present
Second	Albert H. Joslin	Present	Present
Third	J. Nicholas Terhune	Present	Present
Fourth	Lucian Y. Moreman, II	Present	Present
Fifth	Larry P. Griffin	.....	Present
Sixth	Jerry W. Martin	Present	Present
Seventh	Cecil D. Martin	Present	.....
Eighth	William B. Monnig	Present	Present
Ninth	Kelly G. Moss	Present	Present
Tenth	Preston P. Nunnelley	Present	Present
Eleventh	William H. Mitchell	.....	Present
Twelfth	David C. Liebschutz	Present	Present
Thirteenth	Jerald M. Ford	Present	Present
Fourteenth	James R. Pigg	.....	.....
Fifteenth	Emanuel H. Rader	Present	Present

ALTERNATE TRUSTEES

District			
First	James S. Gwinn, Jr.	.....	.....
Second	John W. McClellan	Present	Present
Third	N. H. Talley	Present	Present
Fourth	Salem M. George	.....	.....
Fifth	Gorden T. McMurry	.....	.....
Sixth	Jerry L. Gibbs	.....	.....
Seventh	O. M Patrick	.....	.....
Eighth	Mark F. Pelstring	Present	Present
Ninth	Robert L. McKenney	Present	Present
Tenth	Thomas K. Slabaugh	Present	Present
Eleventh	John M. Johnstone	Present	Present
Twelfth	Scott B. Scutchfield	Present	Present
Thirteenth	Charles T. Watson	Present	Present
Fourteenth	Deborah L. McIntyre	.....	.....
Fifteenth	Paul R. Smith	Present	Present

PAST PRESIDENTS

Past President	Richard F. Hench	Present	Present
Past President	Wally O. Montgomery	Present	Present
Past President	Charles C. Smith, Jr.	Present	.....
Past President	James B. Holloway	Present	.....
Past President	Dwight L. Blackburn	.....	.....

DELEGATES
FIRST DISTRICT

		First Meeting	Second Meeting
BALLARD			
CALLOWAY	R. Gary Marquardt	Present	Present
	Dan Miller	Present	.....
CARLISLE			
FULTON			
GRAVES	Robert D. Fields	.....	.....
HICKMAN	Bruce C. Smith	.....	.....
LIVINGSTON	Stephen Burkhart	.....	.....
MCCRACKEN	Larry C. Franks	Present	Present
	Ronald L. Kelley	Present	Present
	John E. McCracken	.....	Present
	Roland H. Myers, Jr.	Present	Present
	Charles W. Ransler, III	.....	Present
	Peter Allan Ward	Present	Present
MARSHALL	H W. Ford	.....	.....

SECOND DISTRICT

DAVIESS	John Jefferies	Present	Present
	Albert Joslin	Present	Present
	Christopher R. McCoy	Present	Present
	R. Wathen Medley	Present	Present
	Wayne Myers	Present	Present
	Robert Reid	.....	.....
HANCOCK			
HENDERSON	Frank K. Sewell, Jr.	Present	.....
	Rogelio A. Silva	Present	.....
MCLEAN			
OHIO	Robert T. Johnson	.....	Present
UNION	Wallas N. Bell	.....	.....
WEBSTER			

THIRD DISTRICT

CALDWELL			
CHRISTIAN	Irene Y. Villarosa	Present	Present
	Emmanuel J. Battah	Present	Present
	Delmas M. Clardy	Present	.....
	Frank R. Pitzer	Present	.....
	Francis Van Meter, Jr.	.....	.....
CRITTENDEN	Gary V. James	.....	.....
HOPKINS	Wallace R. Alexander	.....	Present
	James M. Bowles	Present	Present
	Charles R. Dodds	Present	Present
	William H. Klompus	Present	Present
LYON			
MUHLENBERG	William L. Miller	Present	Present
TODD	Henry R. Bell, Jr.	Present	Present
TRIGG			

FOURTH DISTRICT

BRECKINRIDGE			
BULLITT	James R. Cundiff	.....	.....
GRAYSON	Craig A. Johnson	.....	Present
	Gregory G. Skaggs	Present	.....
GREEN	William L. Shuffett	.....	.....
HARDIN-LARUE	William M. Carney	Present	Present
	Arvil G. Catlett	Present	.....
	Terrell D. Mays	Present	Present
	William C. Nash	Present	Present
HART	George B. Boeckmann	.....	.....
MARION	Brian F. Scott	.....	Present
MEADE	Raymond L. Mathis	.....	Present
NELSON	Fredericka C. Lockett	.....	.....
TAYLOR	Henry F. Chambers	Present	Present
WASHINGTON	Suk K. Koh	.....	Present

	FIFTH DISTRICT		
JEFFERSON	David H. Bizot	.....	.....
	McHenry S. Brewer	.....	Present
	C. Matthew Brown	.....	.....
	Jerry B. Buchanan	.....	.....
	Peter C. Campbell, Jr.	Present	Present
	Stuart P. Cohen	.....	.....
	Samuel L. Cooper	.....	.....
	John H. Doyle	Present	Present
	Hoyt D. Gardner	.....	Present
	Henry D. Garretson	.....	.....
	Darius Ghazi	.....	Present
	Robert R. Goodin	.....	Present
	Larry P. Griffin	.....	Present
	Harold D. Haller, Sr.	Present	Present
	Kenneth E. Holtzapple	.....	Present
	Albert B. Hoskins, III	.....	Present
	Walter I. Hume, Jr.	.....	Present
	David W. Kinnaird	Present	Present
	Donald R. Kmetz	.....	Present
	Russell T. May	.....	Present
	Kirk D. Morgan	.....	Present
	Ralph C. Morris	.....	Present
	William M. Moses	.....	Present
	Morris Nacke	.....	Present
	Syed M. Nawab	.....	.....
	David H. Neustadt	.....	.....
	Robert L. Nold, Sr.	.....	Present
	Charles R. Oberst	.....	Present
	Lynn L. Ogden, II	.....	Present
	K. Thomas Reichard	Present	Present
	Barton H. Reutlinger	Present	Present
	William J. Sandman, Jr.	.....	Present
	G. Randolph Schrodt, Jr.	.....	Present
	Charles C. Smith, Jr.	Present	.....
	Lowell L. Stokes, Jr.	.....	Present
	Lloyd R. Taustine	.....	Present
	Robert S. Tillett	.....	Present
	Daniel W. Varga	.....	Present
	William P. VonderHaar	Present	Present
	David R. Watkins	.....	Present
	Lolita S. Weakley	Present	Present
	Sam D. Weakley	Present	Present
	Larry J. Wilson	Present	Present
	C. Milton Young, III	.....	Present
	SIXTH DISTRICT		
ADAIR	Oris Aaron	.....	.....
ALLEN	Earl P. Oliver	Present	Present
BARREN	Daryl P. Harvey	Present	Present
	William Marrs	.....	.....
BUTLER	Richard T. Wan	.....	.....
CUMBERLAND			
EDMONSON	Omkar N. Bhatt	.....	.....
LOGAN			
METCALFE	Lawrence P. Emberton	.....	.....
MONROE	James E. Carter	.....	Present
SIMPSON	James M. Pulliam	Present	Present
WARREN	John D. Gover	Present	Present
	Jerry W. Martin	Present	Present
	Paul J. Parks	Present	Present
	James O. Willoughby	Present	Present
	SEVENTH DISTRICT		
ANDERSON			
CARROLL	Jeffrey S. Bisker	.....	.....
FRANKLIN	Joseph J. Dobner	.....	Present
	Willis P. McKee	Present	.....
	Walter Steven Wilson	Present	Present
GALLATIN			
GRANT			
HENRY			
OLDHAM			
OWEN	David F. Smith	.....	.....
SHELBY	Sidney R. Steinberg	.....	.....
	Ron E. Waldridge	Present	Present
	David W. Wallace	.....	Present
SPENCER			
TRIMBLE	Roderick H. MacGregor	Present	Present
	EIGHTH DISTRICT		
BOONE	Dwayne V. Smith	Present	Present
	Don J. Swikert	Present	Present
CAMPBELL-KENTON	Gordon W. Air	Present	Present
	Charles F. Allnutt	Present	Present
	Thomas E. Bunnell	Present	Present
	Luis E. Davila	.....	.....
	Joel G. Kreilein	.....	.....
	Carol S. Milburn	Present	Present
	Mary Redden-Borowski	Present	Present
	Jeffrey W. Russell	.....	.....
	Donald A. Saelinger	.....	.....
	Fred A. Stine	Present	Present
	Steve M. Woodruff	Present	Present
	NINTH DISTRICT		
BATH	Robin A. Byron	.....	.....
BOURBON	J. Roy Biggs	.....	.....
BRACKEN	Milton L. Brindley	.....	.....
FLEMING	Glenn R. Womack	.....	.....
HARRISON	Don R. Stephens	Present	.....
MASON	Audrey Spencer	.....	Present
NICHOLAS	Timothy R. Scott	.....	.....
PENDLETON	Robert L. McKenney	Present	Present
ROBERTSON	R. Lamont Wood	.....	.....
SCOTT	L. Frank McBrayer	Present	Present
	TENTH DISTRICT		
FAYETTE	John R. Allen	Present	Present
	Peter P. Bosomworth	Present	.....
	John W. Collins	Present	Present
	Max Crocker	Present	Present
	John D. Cronin	Present	Present
	Michael E. Daugherty	Present	Present
	Harold T. Faulconer	Present	Present
	J. M. Fox	.....	Present
	William F. Gee	.....	Present
	Ardis D. Hoven	Present	Present
	Thomas M. Jarboe	Present	Present
	Dennis B. Kelly	.....	Present
	William D. Medina	Present	Present
	William R. Meeker, Jr.	Present	Present
	Andrew M. Moore, II	.....	Present
	Franklin B. Moosnick	Present	Present
	John W. Poundstone	Present	Present
	Andrew R. Pulito	Present	Present
	Barry N. Purdom	Present	Present
	E. C. Seeley	Present	Present
	David B. Stevens	Present	Present
	John E. Trevey	Present	Present
	Gary R. Wallace	.....	Present
	Emery A. Wilson	Present	Present
JESSAMINE			
WOODFORD			
	ELEVENTH DISTRICT		
CLARK			
ESTILL			
JACKSON			
LEE	Arnold L. Taulbee	.....	.....
MADISON	John M. Johnstone	Present	Present
	Charles H. Veurink	.....	.....
MENIFEE			
MONTGOMERY			
OWSLEY			

POWELL	Charles G. Noss	.....	.....
WOLFE	Paul F. Maddox	.....	Present
	TWELFTH DISTRICT		
BOYLE	David C. Liebschutz	Present	Present
	Scott B. Scutchfield	Present	Present
CASEY	Lewis E. Wesley	.....	.....
CLINTON	William C. Powell	.....	.....
GARRARD	Paul J. Sides	Present	Present
LINCOLN	Charles E. Crase	.....	.....
MCCREARY			
MERCER	George W. Noe	Present	Present
PULASKI	Donald E. Brown	Present	Present
	Gregory J. Sherry	Present	Present
	Joseph G. Weigel	Present	Present
ROCKCASTLE			
RUSSELL	James E. Monin	.....	Present
WAYNE	John W. Simmons	Present	Present
	THIRTEENTH DISTRICT		
BOYD	Kenneth Hauswald	Present	Present
	Howard B. McWhorter	Present	Present
	Susan H. Prasher	Present	Present
	Bruce Stapleton	Present	Present
CARTER			
ELLIOTT			
GREENUP	Manuel S. Garcia	Present	.....
LAWRENCE	George P. Carter	Present	Present
LEWIS	Karl H. Smith	.....	.....
MORGAN	James D. Frederick	.....	.....
ROWAN			
	FOURTEENTH DISTRICT		
BREATHITT			
FLOYD	Peeter Jakobson	.....	.....
	Nicholas R. Jurich	Present	Present
JOHNSON			
KNOTT			
LETCHER	Arba L. Kenner	Present	Present
MAGOFFIN			
MARTIN			
PERRY			
PIKE	Russell H. Davis, Sr.	Present	Present
	John H. Scott, III	Present	Present
	Mary L. Wiss	Present	Present
	FIFTEENTH DISTRICT		
BELL	Meredith J. Evans	Present	Present
	Charles C. Moore, Jr.	Present	Present
CLAY	William E. Becknell, Sr.	Present	.....
HARLAN	Rachel R. Eubank	Present	Present
	James Kenneth Hurlocker	Present	Present
KNOX	Rogelio A. Acosta	.....	Present
LAUREL	Paul R. Smith	Present	Present
LESLIE	Jean Elizabeth Sullivan	Present	.....
WHITLEY	Terri Lynn Daniel	Present	Present
	Carmel Wallace, Jr.	.....	.....

KMA Resident Physicians Section-William C. Cromwell
KMA Student Delegates-Todd E. Pesavento-UL Student Delegate
Paul Austin-UK Student Delegate

KMA-HMSS-David R. Watkins

The information in the Roll Call was taken from the attendance record cards signed by the delegates prior to the meetings of the House, September 26 and September 28.

STATEMENT OF OWNERSHIP MANAGEMENT AND CIRCULATION

(Required by 39 U.S.C. 3685)

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8. Known bondholders, mortgagees, and other security holders owning or holding 1 percent or more of total amount of bonds, mortgages or other securities: None.
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10. Extent and nature of circulation:

	Average no. copies each issue during preceding 12 months	Single issue Published nearest to filing date
A. Total no. copies printed:	4869	4880
B. Paid circulation:		
1. Sales through dealers and carriers, street vendors and counter sales:	0	0
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C. Total paid circulation:	4228	4214
D. Free distribution by mail, carrier or other means.		
1. Samples, complimentary, and other free copies:	576	606
E. Total distribution:	4804	4820
F. Office use left-over, unaccounted, spoiled after printing:	65	60
G. Total:	4869	4880

REFERENCE COMMITTEES



Reference Committee No. 1: (L to R) John H. Doyle, MD, Louisville; Henry R. "Hank" Bell, MD, Elkton; Don R. Stephens, MD, Cynthiana; John W. Collins, MD, Lexington; Charles F. Allnutt, MD, Covington, Chairman.



Reference Committee No. 2: (L to R) William L. Miller, MD, Greenville; Charles H. Veurink, MD, Richmond; Russell H. Davis, MD, Pikeville, Chairman; C. Milton Young, III, MD, Louisville; Joseph G. Weigel, MD, Somerset.



Reference Committee No. 3: (L to R) Mary L. Wiss, MD, Pikeville; Charles R. Dobbs, MD, Madisonville; Paul R. Smith, MD, London, Chairman; E. C. Seeley, MD, Lexington; David W. Kinnaird, MD, Louisville.



Reference Committee No. 4: (L to R) Larry J. Wilson, MD, Louisville; Ardis D. Hoven, MD, Lexington, Chairman; Frank K. Sewell, MD, Henderson; Donald Brown, MD, Somerset; James M. Bowles, MD, Madisonville.



Reference Committee No. 5: (L to R) Charles C. Moore, MD, Middlesboro; William D. Medina, MD, Lexington; Scott B. Scutchfield, MD, Danville, Chairman; Thomas E. Bunnell, MD, Erlanger; William C. VonderHaar, MD, Louisville.



Reference Committee No. 6: (L to R) John J. Jeffries, MD, Owensboro; Carol S. Milburn, MD, Crestview Hills; Harold D. Haller, MD, Louisville, Chairman; Andrew R. Pulito, MD, Lexington; William C. Nash, MD, Elizabethtown.

The John Giles Cecil, MD Memorial Meeting of the Kentucky Medical Association

***Digest of Proceedings of the Regular Session of the**

House of Delegates

Peter C. Campbell, Jr, MD, Louisville
Speaker of the House, Presiding

First Meeting
September 26, 1988

Peter C. Campbell, Jr, MD, Speaker of the House of Delegates, called the first Meeting of the 138th Session of the KMA House of Delegates to order at 9:00 AM on Monday, September 26, 1988, at the Hyatt Regency Hotel, Lexington, Kentucky. He introduced the Vice Speaker of the House of Delegates, Danny M. Clark, MD, Somerset, and KMA's legal counsel, Charles J. Cronan, IV. Following the invocation given by Albert H. Joslin, MD, Owensboro, the Chairman of the Credentials Committee, Paul J. Sides, MD, Lancaster, reported that a quorum was present. It was noted that additional Credentials Committee members were John W. McClellan, MD, Henderson, and Jean E. Sullivan, MD, Hyden.

A motion was made, seconded, and carried to approve the Minutes of the 1987 Session of the House of Delegates as published in the December 1987 *Journal of the Kentucky Medical Association.*

S. Randolph Scheen, MD, Louisville, Secretary-Treasurer, reported that the Scientific Session would begin at 8:30 AM on Tuesday, and the President's Luncheon would begin at 11:50 AM on Wednesday, at which time the new KMA President would be installed. Doctor Scheen reminded the Delegates that Reference Committees would convene at 2 PM on Monday. Doctor Scheen then asked the Delegates to stand for a moment of silence in memory of KMA members who had died since the 1987 Annual Meeting.

The Speaker announced that each Delegate had a booklet, prepared by the Rules Committee, outlining the rules the House should follow in its deliberations.

Pamela Potter, immediate past president of the Auxiliary to KMA, presented AMA-ERF checks comprised of the funds the Auxiliary had raised to benefit Kentucky's medical schools. Emery A. Wilson, MD, Dean, accepted a check for $16,657.39 on behalf of the University of Kentucky College of Medicine; and Dr. David Weigman, Vice Chairman for Academic Affairs, accepted a check for $24,565.35 on behalf of the University of Louisville School of Medicine.

KMA President Donald C. Barton, MD, presented the Educational Achievement Award to William P. VonderHaar, MD, Louisville, and presented a special award to David L. Stewart, MD, Louisville, for humanitarian service to his patients and to the profession.

Vice Speaker Clark introduced the officers who presented their Reports. Each of the Reports was assigned to a Reference Committee, as noted:

Report Number		Reference Committee
1	Report of the President Donald C. Barton, Corbin	1
2	Report of the President, Auxiliary to KMA Pamela Potter, Ashland	1
3	Report of the President-Elect Bob M. DeWeese, Louisville	1
4	Report of the Speakers, House of Delegates Peter C. Campbell, Jr, Louisville Danny M. Clark, Somerset	1
5	Report of the Chairman, Board of Trustees William B. Monnig, Edgewood	1
6	Report of the Secretary-Treasurer S. Randolph Scheen, Louisville	1
7	Report of the Editor A. Evan Overstreet, Louisville	1
8	Report of the Delegates to AMA Fred C. Rainey, Elizabethtown	1
9	Report of the Executive Vice President Robert G. Cox, Louisville	1

**Editorial Note: A tape recording was made of the two Meetings of the House of Delegates, and any member who wishes to examine the transcript of these proceedings may visit the Headquarters Office and listen to the recordings.*

10	Kentucky Physicians Care Operating Committee Russell L. Travis, Lexington	1
11	KMA Physicians Services, Inc. William B. Monnig, Edgewood	1
12	Kentucky Medical Insurance Company Ballard W. Cassady, Pikeville	1
13	Scientific Program Committee James A. Baumgarten, Louisville	2
14	Scientific Exhibits Committee Richard A. Kielar, Lexington	2
15	Continuing Medical Education Committee James E. Redmon, Jr, Louisville	2
16	Council for Continuing Medical Education James E. Baumgarten, Louisville	2
17	Cancer Committee P. Raphael Caffrey, Lexington	2
18	Emergency Medical Care Seminar Planning Committee E. Truman Mays, Somerset	2
19	Physician Manpower Committee Robert R. Goodin, Louisville	2
20	Interspecialty Council Paul J. Parks, Bowling Green	2
21	Hospital Medical Staff Section William B. Monnig, Edgewood	2
22	Maternal Mortality Study Committee John W. Greene, Jr, Lexington	3
23	Committee on National Legislative Activities Fred C. Rainey, Elizabethtown	3
24	Committee on State Legislative Activities Wally O. Montgomery, Paducah	3
25	Committee on Impaired Physicians David L. Stewart, Louisville	3
26	Committee on Care for the Elderly John C. Wright, II, Louisville	3
27	Committee on Medical Insurance and Prepayment Plans Earl P. Oliver, Scottsville	4
28	Committee on Claims and Utilization Review K. Thomas Reichard, Louisville	4
29	Peerview Oversight Committee James M. Bowles, Madisonville Richard S. Miles, Russell Springs	4
30	Committee to Investigate Changing Trends in Medicine Nelson B. Rue, Bowling Green	4
31	Committee on Maternal and Child Health Danny M. Clark, Somerset	5
32	Technical Advisory Committee on Physician Services (Title XIX) Harold L. Bushey, Barbourville	5
33	Committee on Community and Rural Health Ardis D. Hoven, Lexington	5
34	Committee on School Health, Physical Education, and Medical Aspects of Sports R. Quin Bailey, Danville	5
35	Advisory Committee to CHR William B. Monnig, Edgewood	5
36	Judicial Council Harold L. Bushey, Barbourville	6
37	Rural Kentucky Medical Scholarship Fund Carolyn H. McKinley, Glasgow	6
38	Physician-Attorney Liaison Committee Thomas M. Marshall, Louisville	6
39	Membership Committee Harold D. Haller, Sr, Louisville	6
40	Committee on Constitution and Bylaws Danny M. Clark, Somerset	6
41	McDowell House Board of Managers David W. Kinnaird, Louisville	6
42	Medical Student Section Baretta Casey, Lexington Terry Cleaver, Louisville	6
43	Resident Physicians Section Forrest Hanke, Madisonville	6

Ad Hoc Committee Reports

Ad Hoc Committee on Professional Liability Insurance Wally O. Montgomery, Paducah	3
Ad Hoc Committee on Professional Liability Insurors Charles C. Smith, Jr, Louisville	1

Young Physicians Steering Committee Donald J. Swikert, Florence		6
Special Report A, Voluntary Medicare Assignment Program Board of Trustees		5

New Business

New Business of the House of Delegates was assigned to the Reference Committee indicated:

Resolution	Submitted by	Subject	Reference Committee
A	Board of Trustees	Inappropriate Requirements for Hospital Staff Membership	2
B	Fayette County Medical Society	Tobacco-Free Schools	5
C	Fayette County Medical Society	Child Car Seat Safety	5
D	Jefferson County Medical Society	Premium Discounts to Faculty	1
E	Jefferson County Medical Society	Electronic Voting at AMA Meetings	1
F	Jefferson County Medical Society	Hiring of Faculty for Private Practice	4
G	Jefferson County Medical Society	Out-of-State School Physical Examination Requirements	5
H	Jefferson County Medical Society	Enforcement of Laboratory Regulations	5
I	Jefferson County Medical Society	Voluntary Medicare Assignment	5
J	Resident Physicians Section	ACLS and BCLS Certification for Residents	6
K	Resident Physicians Section	Enforcement of DUI Laws	3
L	J. Gregory Cooper, MD Cynthiana	Availability of Obstetrical Services	3
M	Resident Physicians Section	Written Diagnosis on Prescriptions **(WITHDRAWN)**	
N	Fayette County Medical Society	Warnings Against Use of Alcohol During Pregnancy	3
O	Fayette County Medical Society	DRGs	5
P	Bell County Medical Society	Physician Certification of Cause of Natural Death	3
Q	Bell County Medical Society	Patient Copayments for Hospitalized Medicare Patients	5
R	Bell County Medical Society	Patient Advocacy and Third-Party Payors	4
S	Jefferson County Medical Society	Childhood Immunizations	5
T	Daviess County Medical Society	Compulsory Chiropractic Health Insurance Coverage	3
U	Board of Trustees	Professional Liability Insurance Task Force	3
V	Board of Trustees	Disposal of Medical Waste	5
W	Board of Trustees	Support of Nursing Education	4
X	Board of Trustees	KMA Committee on State Legislative Activities	3
Y	Board of Trustees	Minimum Requirements for Managed Health Care Systems	4
Z	Board of Trustees	Referral of Preoperative and Postoperative Cataract Surgical Patients	3
AA	Board of Trustees	Patient Counseling	5
BB	Board of Trustees	Health Department Ambulatory Care Program	5
CC	Warren County Medical Society	Weekend Transfer from Hospital to Nursing Home	5
DD	KY Society of KOGS - KY Section of ACOG	Carrier Influence on Medical Practice	3
EE	Ky Society of KOGS - KY Section of ACOG	Noninsurance Assets	3
FF	Ky Society of KOGS - KY Section of ACOG	Not-for-Profit Hospital Pricing	3
GG	Ky Society of KOGS - KY Section of ACOG	Neurologically Impaired Newborns	3

Doctor Clark announced the meeting locations for the Nominating Committee and for Trustee Districts electing Trustees and Alternate Trustees. He reminded the Delegates that the Nominating Committee would report at the close of the first Scientific Session on Tuesday morning.

The names of the members of the Nominating Committee were announced: Scott B. Scutchfield, MD, Danville, Chairman; R. Gary Marquardt, MD, Murray; Terrell D. Mays, MD, Elizabethtown; William H. Mitchell, MD, Richmond; and Susan H. Prasher, MD, Ashland.

Speaker Campbell adjourned the first Meeting at 10:30 AM.

Second Meeting
September 28, 1988

Speaker Campbell called the second Meeting of the 1988 Session of the KMA House of Delegates to order at 6:00 PM on Wednesday, September 28, 1988. Paul J. Parks, MD, Bowling Green, gave the invocation, and the Chairman of the Credentials Committee, Paul J. Sides, MD, reported that a quorum was present. Doctor Campbell noted that John M. Johnstone, MD, Richmond; John R. Potter, MD, Ashland;

and Susan H. Prasher, MD, Ashland, would serve as Tellers during the Meeting.

Secretary-Treasurer Scheen recognized guests from neighboring state medical associations who had attended the Annual Meeting. Included were John MacDougall, MD, President of the Indiana State Medical Association; Bill M. Atkinson, MD, President, West Virginia State Medical Association; J. Thomas Hulvey, MD, President-Elect of the Medical Society of Virginia; and William Marshall, MD, President-Elect of the Ohio State Medical Association.

William B. Monnig, MD, Chairman of the Board of Trustees, made a motion, on behalf of the Board, that Will W. Ward, MD, Louisville, be elected to another four-year term on the KMA Judicial Council. The motion was seconded from the floor and carried.

Doctor Monnig then introduced the following Resolution on the Board's behalf titled "Kentucky Kare," and made a motion for its adoption. The motion was seconded from the floor, and following review of the Resolution by the Delegates, C. R. Dodds, MD, Delegate from Hopkins County, was recognized who proposed several amendments to the Resolution. On a hand vote, 77 House members voted for and 89 voted against the amendments. On a vote for adoption of the Resolution as originally written, the motion carried.

Kentucky Kare

WHEREAS, the present administration of Kentucky State Government has adopted a self insurance program for approximately 115,000 State employees called Kentucky Kare, and

WHEREAS, that program contains deductibles of $400 for individual coverage and $800 for family coverage, with a maximum out-of-pocket expense of $1500 for individual coverage and $3500 per family, and

WHEREAS, State employees residing in 66 Kentucky counties have this plan as their only health insurance alternative, and

WHEREAS, these deductibles may create financial hardships for thousands of State employees and their families, and

WHEREAS, while State employees in the remaining 54 Kentucky counties have a choice of the Kentucky Kare plan or various managed care plans, the practical effect of the high deductibles is to make participation in managed care plans the only financially feasible alternative, thereby limiting freedom of choice for employees, and

WHEREAS, patients in certain plans who require hospitalization may be forced to travel long distances to participating hospitals and physicians, even though local providers are otherwise available, thus removing the choice of providers from the patient and their physicians, and

WHEREAS, details of the administration of the plan are unclear and without adequate detail, and

WHEREAS, the Kentucky Kare plan may directly affect the survival or financial viability of rural hospitals and adversely impact the continuity or access to medical care, not only for State employees and their families, but other members of the community as well, and

WHEREAS, the delivery of primary medical care is crucial to a community's ability to grow economically and to attract business and industry, and

WHEREAS, studies and surveys have indicated that inordinate deductibles, such as those required in the Kentucky Kare plan, may delay necessary medical care because of the out-of-pocket cost to the individual, now therefore be it

RESOLVED, that KMA support the position of State employees, teachers, and legislators who contend that the Kentucky Kare plan is an unreasonable plan of health care coverage, and be it further

RESOLVED, that KMA support reasonable efforts of State employees to rectify the inadequacies of the Kentucky Kare plan and work to support changes through meetings with the Executive Branch of Kentucky State Government, legislative leadership, staff, and committees of jurisdiction, and be it further

RESOLVED, that KMA support efforts to deal with the employee health plan dilemma as quickly as possible, to include any future special session of the Kentucky General Assembly, and be it further

RESOLVED, that KMA, as a matter of extreme urgency, ask physician legislative contacts to notify members of the Kentucky General Assembly of its support for the efforts of State employees to make appropriate changes in the Kentucky Kare plan and to encourage the Governor to call a special session of the Kentucky General Assembly to deal with this problem, and be it further

RESOLVED, that the KMA House of Delegates urge all Kentucky physicians to be sympathetic to State employees and their families in this difficult period and to recognize the financial hardships that this change may bring about, and be it further

RESOLVED, that this Resolution be sent to the Governor of Kentucky, Lieutenant Governor of Kentucky, the Coalition of State Employees and related organizations, Kentucky Education Association, members of the Kentucky General Assembly, Kentucky Association of School Administrators, Kentucky Association of Counties, and other affected groups and organizations, and be it further

RESOLVED, that this Resolution be publicized.

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 1

Charles F. Allnutt, MD, Covington, Chairman

Reference Committee No. 1 considered the following Reports and Resolutions:

1. Report of the President
2. Report of the President, Auxiliary
3. Report of the President-Elect
4. Report of the Speakers, House of Delegates
5. Report of the Chairman, Board of Trustees *except* for Recommendation No. 2 (referred to Reference Committee No. 3) and the following Reports:
   Report of the Ad Hoc Committee on Professional Liability Insurance
   (referred to Reference Committee No. 3)
   Special Report A — Physician Voluntary Medicare Assignment Program
   (referred to Reference Committee No. 5)
   Report of the Young Physicians Steering Committee
   (referred to Reference Committee No. 6)
6. Report of the Secretary-Treasurer
7. Report of the Editor
8. Report of the Delegates to AMA
9. Report of the Executive Vice President
10. Report of the Kentucky Physicians Care Operating Committee
11. Report of the KMA Physicians Services, Inc.
12. Report of the Kentucky Medical Insurance Company
    Resolution D — Premium Discounts to Faculty (Jefferson County Medical Society)
    Resolution E — Electronic Voting at AMA Meetings (Jefferson County Medical Society)

ITEMS FOR CONSENT

Reference Committee No. 1 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

3. Report of the President-Elect — filed
4. Report of the Speakers, House of Delegates — filed
6. Report of the Secretary-Treasurer — filed
7. Report of the Editor — filed
8. Report of the Delegates to AMA — filed
9. Report of the Executive Vice President — filed
12. Report of the Kentucky Medical Insurance Company — filed

Mr. Speaker, Reference Committee No. 1 recommends adoption of the Consent Calendar as a whole.

Report of the President-Elect

It has been my privilege to serve you this year as President-Elect. While I have had the benefit of being active in organized medicine's efforts for a number of years, this year has been of particular importance to me. I have had the opportunity to take part in the decision-making process which helps guide the affairs of the Association, and to represent the Association in a number of arenas which have been both benevolent and adversarial.

I would be remiss if I did not make note of the significant efforts made this year by your President, Don Barton. For those of you who are not aware of Don's motivation and talents, it is appropriate to report to you that there are few activities at KMA in which he is not involved. He is an able leader, spokesman, and strategist, and the Association has certainly benefitted from his guidance.

Likewise, you should be aware that Bill Monnig, as Chairman of the Board of Trustees, is a solid, open leader, who has unfailingly brought consensus and logic to all discussions. Bill has the unique ability to quickly work to the core of an issue and has selflessly given his time and talents this year.

Because the Legislature was in session, representation of the Association in Frankfort was needed, particularly in view of our professional liability insurance efforts. Don Barton, Bill Monnig, Randy Scheen, and Wally Montgomery spent countless hours on the Association's behalf with great effectiveness, and we can all be proud of their efforts.

It has been my distinct pleasure to be fully involved, and I am appreciative of everything that the medical profession stands for. KMA is the focal point for that representation, and it is quite gratifying to know that in spite of the difficulties our profession faces socially, legislatively, and economically, we remain true to our guiding ethics. In every forum I encountered this year, respect for the profession and for our efforts was strongly experienced.

During the coming year, I hope to carry on the efforts that were begun relating to our PLI program and to consider developing strategies to initiate patient participation in the socioeconomics of medicine. Patients are the ultimate benefactors of our profession, and we need to give closer attention to the nonmedical influences they must face in the delivery of medical care. While physicians suffer from seemingly interminable administrative requirements, our patients are the final victims of confusing and sometimes inadequate administrative programs.

I urge your comments, criticisms, and expressions of concern. I hope to be able to fulfill the traditions that have been established before me, and I humbly thank you for the honor you have bestowed by choosing me to serve you.

Bob M. DeWeese, MD
President-Elect

Report of the Speakers, House of Delegates

On behalf of the Association, your Speakers would like to welcome you to the 138th Annual Meeting of the Kentucky Medical Association. Every effort will be made to allow open and frank discussion on the issues that will come before the

House of Delegates, and your input is sincerely sought and urged. It is strongly suggested that Delegates share their Annual Meeting information with members in their Districts so that background on these issues can be given the widest possible dissemination.

Major topics before you this year will be: continuation of the Kentucky Physicians Care Program, a proposal for a Voluntary Assignment Program for Medicare recipients, and professional liability insurance. Your views and opinions are vitally needed on these matters.

Your Speakers urge that Resolutions be submitted as soon as possible so that they can be reproduced and furnished to all Delegates before the Annual Meeting. Please note that according to the Bylaws, Resolutions must be received in the Headquarters office seven days prior to the first Meeting of the House. Otherwise, they must be submitted during the first Meeting, but only if a majority vote approves submission.

Your Speakers will do everything possible to make the meetings open and available to all Delegates and members. Your discussions and views are needed. We look forward to a productive session and appreciate your confidence in our efforts.

Peter C. Campbell, Jr, MD
Speaker
Danny M. Clark, MD
Vice Speaker

Report of the Secretary-Treasurer

The Kentucky Medical Association has completed another Associational year, and it is gratifying to be able to report that your KMA remains strong and active in support of your interests.

The Auditors' Report contains a full accounting of KMA's financial status, and we urge you to look this report over and ask any questions you might have about it. Two years ago, a $100 dues increase was approved, which was devoted to legislative efforts dealing with the professional liability insurance crisis. The Reports of the Committee on State Legislative Activities and the Ad Hoc Committee on PLI address the successes that were achieved. Much work remains to be done, however, and the Board of Trustees urges concurrence with its action to maintain and reallocate this increase. The Report of the Chairman of the Board of Trustees provides more information.

You are also requested to closely review the report of the Kentucky Physicians Care Operating Committee and its recommendation to continue that program another year. In a similar vein, the Board has proposed a new program for voluntary assignment of Medicare claims, and this appears as Special Report A of the Board of Trustees.

We have made some significant efforts in membership. This year a video-cassette tape was produced using member participants. This effort was directed toward young physicians, and initial response has been positive. The Membership Committee deserves congratulations.

These highlights of some of KMA's activities this year serve as examples of the many things that have taken place on your behalf, and I hope you will take the time to read all of the reports closely and carefully.

It is appropriate to report to you that your Board of Trustees is a vigorous, active, and effective organ of the Association. As controversial issues arise, they are fully discussed and appropriate action taken. It is a privilege to be a part of that group.

It is a greater privilege to serve you as Secretary-Treasurer, and I express my humble thanks for your confidence in me.

S. Randolph Scheen, MD
Secretary-Treasurer

Report of the Editor

The 1987-88 year was an eventful one for the *Journal of the KMA*. The first complete, overall redesign in the publication's 85-year history took place during this period. We trust the new design has provided a more readable, informative, and up-to-date publication, while maintaining meticulous standards of quality, accuracy, and clarity. During the course of this transition, in an effort to continue to upgrade the quality of the *Journal*, we contracted with a local printer, Gateway Press, Inc., to handle the printing of our publication. This has proven to be a successful move, resulting in a higher quality product, published on a more timely basis, with no increase in cost, as indicated by careful monitoring of expenditures. Our classified advertising policy was upgraded to include commercial advertising at an increased rate, and continues monthly to provide increased revenue.

In January, a milestone was reached with the publication of the "1988 KMA Legislative Handbook," the first time we have ever published a comprehensive collection of legislative information for our membership. This effort was undertaken with the hope that its utilization would equip our members with information necessary to effectively communicate with fellow members and legislative staff and to seek support for KMA's legislative positions from members of the Kentucky General Assembly. It is our hope that this first issue established a precedent and that we can provide our readership with such a legislative handbook in successive legislative years.

In an effort to bring your attention to **your** *Journal* among the stacks of journals, magazines, and other mail you receive daily, a particular effort continues to be made with the cover of each issue to focus in on the material contained in that issue through the use of reproductive material, photographs, or original art produced specifically for the *Journal.*

During the past year, I represented our Editorial Board at the American Medical Writers Conference in Chicago. The four-day event consisted of a very comprehensive presentation for medical writers in preparing, editing, and publishing quality scientific publications. There was special emphasis this year on electronic publishing, especially desktop publishing.

The *Journal* continues as a multifaceted publication with its main thrust being that of bringing matters of scientific interest to the attention of the KMA membership, as well as to subscribers across the country. Original scientific articles are published to a greater degree than other material, with a sufficient balance of articles covering socioeconomic, legal, and philosophic matters. Continuous effort is directed toward being an instrument of communication on issues confronting the profession, as well as the many diverse activities and accomplishments of the Association and its membership.

At this point I would like to personally thank the other editors on the Board: Paul C. Grider, Jr, MD, Scientific Editor; Stephen Z. Smith, MD, Assistant Scientific Editor; and Assistant Editors McHenry S. Brewer, MD; Milton F. Miller, MD; David L. Stewart, MD; and Martha Keeney Heyburn, MD. This Board recognizes and eagerly accepts its position of responsibility concerning the propriety of the material published. In an effort to publish only high quality scientific articles of importance and relevance to our readers, it spends considerable time in reviewing, revising, and making suggestive changes before accepting or rejecting the material which is submitted.

I would also like to thank the University of Kentucky and University of Louisville Medical Schools which continue to be invaluable resources through their Grand Rounds contributions. Both schools are to be commended for their efforts.

Your Board continues to solicit high quality scientific articles and ideas from every member of KMA through original contributions and Letters to the Editor. We wish to assist physicians throughout the Commonwealth in continuing to provide the highest quality of health care to the people of our state and to provide a line of communication to the Kentucky Medical Association. Your Editor and the Editorial Board will continue to strive toward making your *Journal* an even better publication than it has been in the past.

A. Evan Overstreet, MD
Editor

Report of the Delegates to AMA

Your AMA Delegation attended each meeting of the KMA Board of Trustees this past year, in addition to the Interim and Annual Meetings of the AMA House of Delegates.

The Interim Meeting of the House of Delegates was held in Atlanta, December 6-9. The House considered 76 reports and 145 resolutions. Highlights of that meeting were: a report of the Council on Ethical and Judicial Affairs providing guidelines to physicians on issues related to the AIDS epidemic; a comprehensive report on professional liability insurance; several reports and resolutions addressed the continuing problems physicians are having with the administration of the Medicare program; a resolution was adopted asking the AMA to aid and encourage individual state medical societies to develop voluntary Medicare assignment programs similar to the one the KMA House will consider; lengthy debate on reports and resolutions regarding inequities in Medicare's maximum allowable charge limits, and the House-approved policy to seek legislation to eliminate unfair fee distortion created by the current MAAC implementations, among other corrective measures; consideration of a report on current PRO developments and an increased willingness of federal PRO officials to listen to the concerns of physicians; recommendations regarding resident physician working hours and supervision; status of the nursing shortage in the U.S.; encouragement of state and county medical societies to foster greater participation of foreign medical graduates in leadership positions at all levels of organized medicine; and discussion of a status report on the Harvard/AMA Relative Value Study.

At the Annual Meeting held in Chicago, June 26-30, James E. Davis, MD, was installed as President, and Alan R. Nelson, MD, was selected as President-Elect. In his inaugural address, Doctor Davis called on the medical profession to reaffirm its commitment of service to the nation, and cited the Kentucky Physicians Care Program as an example of an effort to meet the medical needs of the indigent. A resolution adopted by the KMA House and subsequently introduced into the AMA House called for third-party payors to accept the physician's prescription as proof of need for durable medical equipment. The resolution was referred to the Council on Medical Services which, after considerable research and discussion with third-party carriers, recommended that the AMA urge public and private payors and consumer organizations to increase their educational efforts directed toward patients and subscribers regarding conditions for coverage for durable medical equipment.

Other highlights of the meeting were: a report of the Board of Trustees proposing a pilot program to create a Registered Care Technologist designation in response to the severe shortage of nurses, which generated considerable controversy among nurses, but which was adopted by the House; reaffirmation of current Association policy on AIDS education, adequate public funding, mandatory and voluntary testing, access to HIV testing and vigorous enforcement of existing antidiscrimination statutes; adoption of policy for AMA to seek repeal of the MAAC provision, support federal legislation that would rectify Medicare contractual inequities with physicians and patients, and continue to oppose differential treatment of "participating" and "nonparticipating" physicians; approval of policy to seek repeal of the requirement that carriers send out "medically unnecessary" denial forms; adoption of a comprehensive report that addresses legal liability

concerns of physicians participating in peer review; adoption of an increase in dues of $25 to $400 for active members, while dues for residents and students remain unchanged; adoption of a report calling for a full evaluation of the resource-based RVS for physician services to be completed before implementation decisions are made, and that a reasonable transition period be included before any adoption of a Medicare fee schedule; and adoption of a report recognizing the value of office-based testing and the need to assume the quality of that testing.

Donald J. Swikert, MD, Florence, was honored by the AMA for his efforts in recruiting 32 new members to federation membership through the Young Physician Outreach Program. The Delegation is pleased with the interest of the students, residents, and young physicians from Kentucky who have attended and participated in AMA meetings this year.

I appreciate the long hours and hard work put in by the Delegates and Alternates and extend my personal thanks to: Kenneth P. Crawford, MD; Donald C. Barton, MD; Russell L. Travis, MD; Wally O. Montgomery, MD; Robert R. Goodin, MD; Harold L. Bushey, MD; and Carl Cooper, Jr, MD.

Fred C. Rainey, MD
Senior Delegate

Report of the Executive Vice President

Perhaps never in the history of Kentucky medicine has the profession been so united, so determined, and so involved.

Professional liability reform, the current number one priority as established by the House of Delegates, received the full attention of the Officers and staff, and we are pleased to report that we feel we had the best Legislative Session in KMA's history. The real winners in the liability campaign are the three million plus patients of Kentucky physicians. This has been an unprecedented year and all of us should be proud of our accomplishments.

Even though the liability campaign garnered much of our attention, other KMA activities and functions continued unabated. As you will see by the Final Reports, over fifty regular and ad hoc committees worked on behalf of physicians and patients improving medical standards and supporting the profession. Over 400 members served on committees, 138 members served as Key Legislative Contacts, and in excess of 2,200 members participated in the Kentucky Physicians Care Program. When you combine these numbers, which don't include local participation, it indicates the personal commitment physicians have for their profession and communities. It is also evidence that KMA is a working Association and a participatory organization.

Under the umbrella of KMA, specific committees represent students, residents, hospital medical staffs, 24 specialty societies, foreign medical graduates, and young physicians. We conducted seminars to teach residents how to start their practices; seminars to teach members and their staffs third-party reimbursement techniques and contract analysis; seminars to teach retiring members how to close their practices; and a legislative seminar to educate members in the political process and provide information regarding KMA's legislative program.

In this Report we will concentrate on representation, the major reason physicians join a medical organization. This Report concentrates on five major areas of KMA representation. In addition, separate sections will examine finances and staff activity.

The overall purpose of KMA is to represent the interests of the individual physician, the profession, and its patients. We represent you on five basic levels which include scientific, socioeconomic, public, political, and federation.

Scientific

A major objective of this Association is to promote the extension and advancement of medical knowledge and science. The Annual Meeting of KMA is the centerpiece of KMA's effort to achieve this goal. Over 1,200 physicians attended and participated in KMA's 1987 Annual Meeting. Following the 1987 Meeting, we surveyed participants regarding the Annual Meeting and their preferences for subject matter. Sixty-six percent of those who responded supported the concept that Annual Meetings remain scientific rather than focusing on socioeconomic or other topics.

We again sponsored the Emergency Medical Care Seminar which hosted over 400 physicians, nurses, EMTs, paramedics, and other emergency personnel. The annual Seminar is recognized for its effort to upgrade emergency care throughout Kentucky.

Through the Committee on School Health, Physical Education, and Medical Aspects of Sports, we sanctioned and sponsored eight seminars throughout the State for high school head coaches in high-risk sports. The symposiums assist coaches in dealing with medical emergencies. The Committee provided over 50,000 brochures on "Athletic Drug Problems" to high school athletes.

We printed and provided copies of "Let's Give America the Facts About AIDS" to every member of the Kentucky General Assembly and staff. In addition, we reprinted the information in the *Journal* for all members of KMA. The Community and Rural Health Committee continues to advise the KMA Board on issues relating to AIDS and to update members on other matters relating to epidemiology and general health concerns in the Commonwealth.

The Maternal and Child Health Committee continues its important task. The Committee on Continuing Medical Education is in the process of developing programs and improving accreditation procedures. The KMA *Journal* maintained its ranking as one of the finest state medical journals in the U.S. The Editorial Board and staff have just completed a total

restructuring of the monthly scientific messenger of KMA, and have improved general articles and upgraded news sections of interest to physicians. As you can see, KMA remains committed to scientific enlightenment of its members and places high priority upon this particular aspect of KMA's agenda.

Socioeconomic

While this report will not address in detail the 1988 liability campaign, I trust members fully understand the difficulty we faced in enacting tort reform and the roadblocks the Kentucky Constitution places in the way of liability reform. We were able to hurdle several obstacles, nonetheless, and pass a rather comprehensive package. We plan to continue our quest for liability reform and concentrate our efforts to alter or eliminate Section 54 of the Constitution, which most experts agree is where "real reform" lies. There's more to be done — and we know it. Plans have been developed and presented to the House of Delegates refining our goals and limiting our efforts to reform that will have a lasting impact. Special thanks goes to organizations of the Tort Reform Association of Kentucky (TRAK), and their respective members, who helped spearhead the 1988 liability reform effort.

In conjunction with the PLI Campaign, we conducted a press and media campaign to educate the public, the profession, and legislative members on the effect the liability crisis has on cost and availability of medical care. The campaign's overall purpose was to achieve a favorable public attitude and was a tremendous success. Two of Kentucky's finest public relations firms conducted the campaign.

In another significant matter, KMA attempted to intervene in a court case in June contesting the constitutionality of confidentiality of peer review. While the courts declined our request to become a party to the suit, the judge nevertheless ruled in favor of our position and upheld the statute.

We conducted several membership surveys to determine physician attitudes on various issues and reported those results to members. As noted earlier, we sponsored several seminars.

We are working very closely with the Kentucky Nurses Association, Kentucky Hospital Association, and the Kentucky Association of Health Care Facilities on the nursing shortage. We are involved with three separate committees studying the shortage. We continue to maintain a close relationship with the Kentucky Hospital Association, Kentucky Dental Association, and Kentucky Pharmacists Association, which comprise the Allied Health Council, and confer on a quarterly basis to discuss mutual and individual concerns.

KMA Officers and staff communicated with major health insurors pointing out various problems physicians and patients have with insurance company forms, policies, and conflicting coverages. In addition, we held discussions with the Insurance Commissioner and his staff on two occasions regarding third parties and the inequities that exist within the health insurance industry, and another meeting with the same group regarding liability insurors. We are optimistic that these meetings will bring some relief and some change in these areas.

Public

The overriding medical issue is AIDS. In 1987 KMA appointed a special ad hoc committee which presented a report at the last Session of the House of Delegates. As noted earlier, this year we reprinted a modified booklet previously developed by AMA and the Department for Health and Human Services, "Let's Give America the Facts About AIDS." The modified booklet included the KMA report and additional material we thought would be of interest to legislators. We provided copies to legislators, staff, lobbyists, and other appropriate individuals. We continue to provide speakers, assist the media, and participate in various forums and seminars across the state regarding the AIDS problem. During the Kentucky General Assembly we successfully opposed several AIDS bills that were punitive and not in the public's or the profession's interest.

KMA continues to reprint the brochure, "Reporting and Recognizing Child Abuse." It is used by school systems, health facilities, law enforcement agencies, and other groups to identify and report child abuse. The Committee on Care for the Elderly is in the process of developing a brochure on elderly abuse which we plan to distribute. The KMA Cancer Committee has completed its suggested revisions to the breast cancer pamphlet and has been instrumental in revising it in accordance with House of Delegates' wishes.

Internal committees which operate to protect the public include the Judicial Council and the Impaired Physicians Committee. These committees are extremely active and work closely with the Board of Medical Licensure to protect patients and the profession from physicians whose practices may jeopardize the public. Once again, in 1988 KMA worked with the Board of Medical Licensure and supported legislative efforts to strengthen the Medical Practice Act.

The Kentucky Physicians Care Program remains the hallmark of the Association's public concern and reasserts the profession's historical record of serving the poor. Over 2,200 physicians express that commitment by participating in the Kentucky Physicians Care program. We are considering a similar plan to assist the elderly poor with a Medicare Assignment Program. These programs are "proof positive" that physicians are the appropriate advocates for patients; not planners, politicians, or bureaucrats.

Finally, we continue to maintain the McDowell House in Danville, the historical home of world-renowned surgeon, Ephraim McDowell, MD. KMA's operation of the McDowell House provides an outstanding public service, benefiting thousands of Kentuckians and tourists annually, and provides a lasting tribute to one of Kentucky's great citizens. We more recently formed a McDowell Foundation for the purpose of receiving an expected substantial gift.

Political

During the 1988 Kentucky General Assembly, we utilized one part-time and three full-time lobbyists in Frankfort representing the interests of physicians. These efforts were augmented by the full support of KMA Officers and staff. The KMA Legislative Committee met five times, the Quick Action Committee 15 times, and the Ad Hoc Committee on Professional Liability Insurance convened once. As you will note in the PLI and State Legislative Committee Reports, we had an extremely successful Session.

On the national front where news is not always comforting, KMA Officers and staff worked closely with AMA staff in contacting the Kentucky Delegation. Kentucky's Congressional Delegation, with a few exceptions, is extremely supportive of medicine. KEMPAC, the political arm of KMA, often goes unnoticed and is frequently criticized by some of our nonpolitical brethren. KEMPAC is one of the four major political action committees in the Commonwealth. KEMPAC's contributions to candidates with philosophical ties to medicine are the foundation to KMA's political success. In this year's primary races alone, KEMPAC contributed in excess of $82,000 to candidates favorable to medicine. Legislators are fully aware of KEMPAC and its concern with the political process.

KMA worked extensively with departments and officials in Frankfort this year closely watching the Labor Department as it developed regulations relating to the 1987 Workers' Compensation Act. We continue our liaison with the Cabinet for Human Resources (CHR). A KMA member, Harry Cowherd, MD, of Frankfort is the CHR Secretary. We were extremely pleased with Doctor Cowherd's appointment and look forward to working with him during his term in office. We continue to monitor and comment on regulations relating to the profession and patient care and will maintain a strong presence in Frankfort during the Interim legislative period.

Federation

KMA constantly strives to strengthen ties within the federation of medicine. We worked with county medical societies in cosponsoring third-party reimbursement seminars and special membership phonathons. We increased our communication with county society secretaries and communicated extensively with local officers and staff on membership and other concerns. Our relationship with AMA continues to grow, and we just completed a video, cosponsored by AMA, directed toward recruitment of young physicians.

KMA President Donald C. Barton, MD, and I traveled to Chicago for an update on the Resource-Based Relative Value Scale (RBRVS) proposal. AMA, states, and counties, along with the specialty societies, need to work closely on this proposal which, if adopted by Congress, will have an immediate and long-term effect on every medical practice. Now is not the time for individuals or groups to play "Lone Ranger."

KMA recognizes medical specialty societies' role, particularly in the scientific and public arenas. Our Specialty Services Department at KMA is specifically geared to provide administrative and secretarial assistance to specialty groups. We maintain direct contact with specialty groups through the Interspecialty Council, which is composed of 24 specialty groups. KMA also maintains a communicative link with national specialty societies, providing assistance upon request.

The KMA Auxiliary is a major resource to medicine and a vital force in the Commonwealth's health and medical affairs. KMA provides office and secretarial support to the Auxiliary of the Kentucky Medical Association (AKMA), and assists in various projects upon request. The Auxiliary's support and participation in the PLI and legislative campaign was extremely beneficial.

We continue to review our internal structure and redefine priorities. Annually, Officers and staff update committee membership and responsibilities and research ways committees can better serve the Association. This year an ad hoc committee reviewed the KMA election process and rules governing the Officer and Trustee elections. We also appointed an ad hoc committee to review liability insurors to determine how their administrative procedures and policies affect the cost and availability of liability insurance. We continue to study health insurance companies to determine their impact on health cost, access to care, and quality of care.

Finances

To maintain the Association's good fiscal health for the future, we are at that time when we need to strengthen the general fund and get the budget nearer to a break-even basis. Our ongoing five-year dues plan calls for a dues increase this year. However, since the House voted a $100 increase two years ago for PLI purposes and PLI funds do not need to be continued at the same level today, the Board recommends that current dues remain the same, but be reallocated. Such an action would permit KMA to remain fiscally strong, and no dues increase should be indicated for at least five more years. The Reserve Fund is the key to our financial stability without increased dues.

Staff

Staff level remains stable as it has for several years. We are pleased to report that William T. (Bill) Applegate has just completed his 20th year with KMA. Bill, Executive Director of KMA, has done an outstanding job for the Association. Our executive staff *averages* over seventeen years' experience at KMA and that helps us keep staff at a minimum. We are proud of the members of our staff and their willingness to do whatever it takes to get the job done. During the General Assembly they were extremely responsive and produced effectively in a team effort.

We also want to introduce our newest executive staff member, Billy J. Mabry, who fills the position previously occupied by William E. Doll. Mr. Mabry is an attorney and will be doing a lot for us in the governmental and medical-legal fields. Members of the executive staff and the entire office staff have my deepest respect. I appreciate them more every day and every year.

As you can see from the summary of 1987-88 activities, this has been a year of hard work and accomplishment. It is clear that KMA is the only statewide organization that represents "all physicians all the time." We believe that physicians agree with our programs and goals, which is evidenced by the fact that membership in organized medicine increased in every category this year. We strive to represent, assist, and provide programs and incentives for physicians from the time they enter medical school to the day they retire. The "cradle to the grave" approach is our goal, and we believe this year's efforts have moved us closer to that goal.

While it can be dangerous to recognize a few individuals in a report, I believe it is appropriate to call your attention to several individuals who have gone beyond the usual call of duty. The key to the success of the PLI Campaign was the role the Board asked Immediate Past President Richard F. Hench, MD, to fill. The PLI Campaign has been a three-year ordeal for Doctor Hench. He was designated and served as KMA's public, legislative, and physicians' spokesman since the campaign started.

Doctor Hench served on the Legislative Task Force which ultimately made the recommendations adopted by the Kentucky General Assembly. The Liability Insurance Task Force met over an 18-month period, meeting often, late, and at scattered locations. It was only through Doctor Hench's persistence that several of KMA's proposals were included in the final package. During the General Assembly he met weekly with the Quick Action Committee, worked with the Ad Hoc Committee on PLI and KMA Legislative Committee, and testified on behalf of KMA. He did a magnificent job, and we owe him a debt of gratitude.

Doctor Wally Montgomery, our indefatigable leader, did an outstanding job of chairing the PLI Campaign and the State Legislative Committee. He spent approximately two days a week in Frankfort from January through April at a considerable sacrifice to his family and his medical practice. All who have traveled Kentucky know that it is a long way from Paducah to Frankfort. I certainly salute him.

William Monnig, MD, our Chairman of the Board, is to be congratulated for his guidance through many decisive periods during the Session. He speaks eloquently for physicians and has a keen understanding of physicians' reaction to legislative proposals. Bob DeWeese, MD, our President-Elect, worked side by side with us in Frankfort and went the extra mile to see that the PLI Campaign and our legislative program were successful. We look forward to working with Doctor DeWeese next year. S. Randolph Scheen, MD, our Secretary-Treasurer, did his usual outstanding year-round job. We are always grateful for the many personal sacrifices he willingly makes to serve KMA and Kentucky physicians. He works side by side with us so frequently, we look upon him as an extension of our staff.

Finally, I can't say enough about President Don Barton. Doctor Barton has served in practically every capacity at KMA and represents physicians of Kentucky first and foremost. It has been a pleasure to work with and for him and to watch KMA grow under his leadership. His duties have taken him on long and numerous trips. He deserves applause.

In summary, let me thank the House of Delegates, members of the Board of Trustees, and especially the membership for their strong support in an extremely difficult year. You were there when we needed you, and your efforts made the difference. We have a long way to go before we reach our ultimate goals. Our plans are laid, and with your continuing support and active involvement, I am confident success will be ours.

Robert G. Cox
Executive Vice President

Report of the Kentucky Medical Insurance Company

On July 28, 1988, the Kentucky Medical Insurance Company (KMIC) celebrated the ten-year anniversary of the Company's incorporation. Today, KMIC insures approximately 2,500 Kentucky doctors and is the state's largest provider of medical professional liability insurance.

During the past year, there have been three changes on the KMIC Board of Directors. Most recently, Richard F. Hench, MD, of Lexington was elected to fill the seat of David A. Hull, MD, who has retired from active practice and from the Board. Doctor Hench was President of KMA in 1986-87 and served as Chairman of the KMA Board of Trustees in 1981-83. He was the only physician member of the Legislature's Kentucky Insurance and Liability Task Force on tort reform during 1986-87.

Also newly elected to the Board of Directors in April was Jane Bramham, MD, an oncologist with the Graves-Gilbert Clinic in Bowling Green, and James Wilkinson, MD, an orthopedic surgeon in Paducah. They replaced James B. Holloway, MD, of Lexington and George Fisher, an Ohio insurance executive.

As of June 30, 1988, KMIC had over $45 million in assets. For the first six months of 1988, KMIC reported a net income of $819,727 to be added to capital and surplus which now exceed $4.3 million.

The financial strength of the Company was demonstrated during the year by the following developments:

1. An independent audit by Arthur Young & Company reported an unqualified opinion that KMIC's year-end financial report was found to "present fairly the finan-

cial position of the company in conformity with generally accepted accounting principles."

2. Tillinghast, Nelson & Warren, Inc., an independent actuary, completed and provided to the Kentucky Department of Insurance a full, detailed review of KMIC's claims reserves as required by Kentucky law for domestic medical malpractice insurance companies. Tillinghast certified in writing to the Department of Insurance that KMIC ". . . has made a good and sufficient provision for all unpaid loss and loss adjustment expense obligations."
3. The Kentucky Department of Insurance completed its quadrennial examination of KMIC and accepted the Company's financials and established reserves without making any adjustments to the capital and surplus account.

Because of KMIC's substantial growth in recent years, increased attention is being given to the accumulation of capital and surplus to support that growth. Additional capital and surplus are needed to have a healthy ratio between surplus and the risks assumed through written premium. Also, additional capital and surplus are required for KMIC to expand its efforts to decrease premiums for professional liability insurance. With greater surplus on hand, individual risks can be covered in-house and our reinsurance costs will be lower. These savings can and will be passed on to policyholders.

During the past year, KMIC has expanded services and reduced costs by providing for our policyholders:

1. Punitive damages coverage at no additional premium,
2. Retirement age lowered to 55 years for free tail coverage and credit for retirement tail coverage earned starting at 51 years (effective April 1),
3. Practice Reduction Premium Rating Program for semiretirement,
4. Suspension of Coverage Program for short-term and extended periods, and
5. A deductible policy.

Beginning in March, more than 1,600 policyholders attended 25 KMIC Claims Prevention seminars in 12 cities from Paducah to Prestonsburg. A separate claims prevention program for medical assistants is also being continued this year.

KMIC shareholders and policyholders received KMIC's 1987 Annual Report in March, along with a booklet entitled *The Next Step*. Both of these publications outlined KMIC's developing strategy for growth and diversification, and reported a strong financial position.

In the May issue of *The Physicians' Advocate*, KMIC reported a very successful trial record to date, winning 83% of its cases in 1979-87 and 86% of its cases in 1987 alone. KMIC was victorious in 30 out of 35 cases it tried throughout Kentucky during 1987.

During the second quarter, KMIC and three other physician-owned medical professional liability insurers formed a reinsurance company, Specialty Underwriters Reinsurance Facility, Ltd. (SURF). Although KMIC and the other companies are currently reinsured in the London market, SURF was formed to retain a portion of each company's reinsurance premiums and potential profits. SURF is not expected to begin operations or become fully capitalized until early 1989.

In July, KMIC established a hospital division that will develop general and medical professional liability insurance products for hospitals. KMIC will underwrite policies for hospitals and their employees.

KMIC continues to offer Kentucky physicians additional services through the KMA Insurance Agency, Inc., the KMIC Investment Company, and the KMIC Leasing Company. These subsidiaries provide services to doctors and generate profits which assist KMIC's efforts to reduce professional liability premiums.

KMIC will host a breakfast during the 1988 KMA Annual Meeting in September. At that time, we will present plans for a major stock offering to Kentucky physicians. This offering is being conducted as a part of KMIC's capital-raising program for strengthening our capital and surplus position.

As your company grows, we also recognize the pressures and competition that have come into the medical professional liability market. It is KMIC's responsibility to fulfill our mission of providing Kentucky doctors with a stable, ongoing source of professional liability insurance at a price that is as reasonable as possible. As we fulfill our mission, we must also recognize the need to establish adequate reserves in order to avoid the chaos that underpricing and fiscal failures can bring to an insurance market.

We intend to remain a professional company, serving a professional market.

Ballard W. Cassady, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the President

The past year has been an enjoyable one for me, as I hope it has been a successful one for the Association. Joan and I truly appreciate the Trustee meetings we attended throughout the state. We made many new friends and renewed old acquaintances, while reporting on the Association's many accomplishments. It is very difficult to recap all the activities of this past year, so I encourage you to read the Committee and Officers' reports included in the House of Delegates book.

Medical Liability

We had a very successful year in Frankfort, and I will not go into detail, as a full discussion is given in the legislative report. However, we have just begun, and must continue to work diligently until we achieve constitutional reform and

pass other meaningful tort reform legislation. I want to commend all of you for the time you gave to the PLI Campaign and urge you to continue this same fine effort through 1990. Special thanks to Wally Montgomery for his fine leadership as Chairman of the Committee on State Legislative Activities.

Indigent Care

Due to budget restraints, nothing was accomplished in this area during the 1988 Legislative Session. However, this issue remains with us. It is a very difficult problem, with no easy solutions. However, I am convinced that we, in cooperation with government and business, can reach a satisfactory outcome acceptable to all. In the meantime, I urge you to continue your support for KMA's Kentucky Physicians Care Program. It has provided us favorable publicity and does help us when dealing with the Legislature. I realize that some of you are carrying the brunt of this program, but bear with us a little longer.

Resource-Based Relative Value Scale

Nationally, this is the hot topic for the coming year. The important thing we must accomplish is to remain unified. We cannot afford to become splintered on this issue, or we will all lose. There will be plenty of time, after the report becomes available, to discuss and cuss what it contains and then develop the response best for all of medicine.

Membership

Membership is the lifeblood of any organization, and each member should constantly strive to bring nonmembers into the Federation. I'm happy to say that KMA's membership is up this year, as well as AMA's and KEMPAC's. We must continue to work diligently with students, residents, and young physicians, as this is where potential new members are. Young physicians are the leaders of the future, and we need to involve them.

Voluntary Medicare Assignment

Although we did not face mandatory Medicare/Medicaid assignment tied to licensure during the 1988 General Assembly, it has not gone away. We have many elderly in our state who simply can't afford the out-of-pocket expenses under the present system. The Board has considered a proposal for voluntary Medicare assignment, which will be presented at this meeting. I don't know, at this writing, whether you will be asked to vote on this now or next year, but I urge you to give KMA leadership your pros and cons on this proposal.

I want to thank the entire staff of KMA, under the able leadership of Bob Cox, for their work and support. We have the best Association staff in the whole country, and we can be rightly proud of them.

In conclusion, let me congratulate the Officers and Board for the fine job they have done. However, I must single out Bill Monnig for the support and leadership he provides as Chairman. Thanks to all of you, because without your support we would have no Association. Last, but not least, I thank my wife, Joan, for her patience and help.

Donald C. Barton, MD
President

Recommendations, Reference Committee No. 1

Reference Committee No. 1 reviewed the Report of the President. The Committee wishes to thank Doctor Barton for his leadership and service to the physicians of Kentucky during the past year as President of the Kentucky Medical Association.

Reference Committee No. 1 recommends that the Report of the President be filed.

Report of the President, Auxiliary

When I began my term as President of AKMA, I challenged auxilians to turn their visions into realities. During the year, we faced the same problems many other volunteer organizations face today. We turned those problems into opportunities for growth, and we are proud of our accomplishments.

AMA-ERF contributions continued to flow in from successful state and county fund-raising projects. The University of Louisville received $24,565.35 and the University of Kentucky received $16,657.39 from last year's AMA-ERF contributions. Contributions for 1987-88 were $52,678.24. At the AMAA Annual Meeting in June, Boyd County was recognized as the county having the second highest per capita contribution in the nation. AKMA was also recognized as the state having the second highest per capita contribution in the country.

Auxiliaries across Kentucky provided many successful health and community service projects. This year the AMA Auxiliary has focused on adolescent health. Kentucky auxiliaries have responded with programs on teen pregnancy, substance abuse, and AIDS education to name a few. The improved sharing of health projects information by county auxiliaries has resulted in the spread of other successful health projects across the state.

AKMA offered AIDS education programs at both its Leadership Conference and Fall Board Meeting. Several county auxiliaries followed this lead and scheduled their own programs. Auxilians, acting individually or through their county auxiliaries, are participating in AIDS education programs in their communities.

Our support of McDowell House and the Ronald McDonald Houses continued. The bylaws of the Health

Careers Loan Fund were amended to provide for grants as well as loans to students in the allied health professions. We anticipate that this change will allow us to assist more students in the future.

I wish that I could report that our membership has grown by 10% this year, but I cannot. I am pleased, however, that many of our counties have increased their membership totals. Special efforts were made to improve communication with and to provide membership assistance to our smaller county auxiliaries. The special recruitment challenges faced by auxiliaries in large metropolitan areas have been addressed through workshops and visits from national representatives.

Work was begun on the organization of new county auxiliaries in both Perry and Clark Counties. With the assistance of KMA, special emphasis was placed on the recruitment of members-at-large and, as a result, our MAL membership increased approximately 30% over the previous year. AMAA gave our Auxiliary special recognition for having more than 75% unified membership.

Legislation was a very special interest of auxilians. The Fayette County Auxiliary participated in a statewide phone bank during the 1988 Legislative Session. A legislative alert system was organized through the county auxiliaries. Auxilians worked with their medical societies on educational and letter writing campaigns. More than 80 auxilians attended the Auxiliary's "Day at the Capitol."

I am indebted to each AKMA Board Member and county leader for the tremendous job they did. I am grateful to each member of AKMA, for it is their participation and support that has made the Auxiliary strong. I appreciate very much the encouragement and support the Auxiliary received from the leadership and staff of KMA as we worked together to achieve our common goals.

Pamela H. Potter
President

Recommendations, Reference Committee No. 1:

Reference Committee No. 1 reviewed the Report of the President, Auxiliary. The Committee wishes to thank Mrs. Potter for her leadership and service during her year as President of the Auxiliary of the Kentucky Medical Association.

Reference Committee No. 1 recommends that Report No. 2 be filed.

Report of the Chairman, Board of Trustees

When I was first elected Chairman of your Board of Trustees, I had no idea of the wide range of activities in which I would be involved. Having served in this capacity for almost a year now, I can state with authority that it has been a demanding, but rewarding, learning experience.

We've accomplished a great deal this year. Of course, everyone knows of the legislative successes in the area of tort reform, and we congratulate Wally Montgomery, Dick Hench, and all the others who worked so long and hard in this effort. Other reports will deal with the PLI issue in more depth, but we want to take this opportunity to express our gratitude to the members of your Board, through its Executive and Quick Action Committees, for the tremendous amount of time and effort expended during the 1988 General Assembly on this and many other legislative matters. I'm sure our membership does not realize how much of an effect KMA's presence in Frankfort has on the quality of medical care in this state. Without a strong and united voice representing all physicians, the future of our profession and the medical standards we uphold would be adversely affected.

If tort reform legislation had been our only accomplishment, it almost would have been enough. But that was only a part of our activities this year. I was surprised, in talking with physicians during our membership phonathons, that so few actually knew what the Association does on their behalf.

I encourage every member to read the annual Reports of your Officers and your committees. These are compiled as a summary of the year's activities and as a report to you, the membership, that the Association is still fulfilling the purposes our founders outlined in the Constitution over 137 years ago.

During 1987-88, we've dealt with a number of issues of importance and concern to the medical profession ranging from liability insurance, medical legislation, and alternate delivery systems to physician manpower, foreign medical graduates, the nursing shortage, elderly and indigent health care, the Relative Value Scale proposal, and AIDS. We've sponsored several well-attended seminars on such topics as evaluating contracts, employee relations, insurance coding, preparing young physicians for managing a practice, and planning for retirement. We've continued to provide continuing education for members and other allied health personnel through such functions as the Annual Meeting and Emergency Medical Care Seminar.

We've educated the public on child abuse and athletic drug problems through the publication and distribution of brochures to schools and day care centers throughout the state. In addition, KMA has provided members with public education materials on the liability issue and managed care plans.

This is a brief overview and, again, I urge you to read the committee Reports for more details on these and many other activities. You will not only be impressed by the volume and scope of the work undertaken, but you will be humbled by the dedication and commitment of the many physicians who meet, discuss, negotiate and, when necessary, fight with bureaucratic agencies, insurance companies, alternate delivery systems, hospitals, and peer review organizations to assure that the interests of our members and their patients are protected.

Few professional organizations — if any — have devoted

as much time, energy, and resources for the benefit of the general public and its membership as has the Kentucky Medical Association. Yet, we still have a number of physicians in this state who have chosen not to support these efforts. Our agenda for the future is long. How much more could we accomplish if everyone participated! Let physicians in your community know what the Association is doing. Share these reports with nonmembers and urge them to join us.

I feel fortunate to have been a part of the leadership this year and to have seen first-hand the many positive results of organized medicine. I want to thank the Trustees of the Association, the KMA staff, the committee members, the House of Delegates, and the entire membership for your dedicated efforts and support this past year.

Our biggest debt of gratitude goes to the KMA staff. Robert G. Cox, Executive Vice President, through his senior management team, has created and maintained a staff organization that is unsurpassed throughout organized medicine. The staff is a constant up-to-date source of pertinent information and is able to assist your leadership in developing responsible positions and action plans on the wide variety of issues that come before the Kentucky Medical Association. Without their expertise and smooth organizational structure, we, the leaders of the KMA, would not be able to function successfully in your best interests.

Dues

The KMA Board of Trustees is not recommending any change in the current Regular, Active Member dues of $400 per year, and anticipates that no dues increase will be necessary for at least five more years.

At the House of Delegates' meeting in September 1986, Resolution O was adopted, which stated: "Resolved, that the dues increase of $100 per member per year be limited to two consecutive years, and that after those two years, the dues be reviewed and changed, if needed, by further action of the House of Delegates."

KMA is on a five-year dues plan, and our last increase for dues for the General Fund was voted in September 1983. Thus, it would normally be time to vote another increase. However, in 1986 the House raised dues by $100 for the purpose of establishing a Professional Liability Insurance Campaign Fund. It is the Board members' opinion that the $100 should now be redistributed as of January 1, 1989, (in lieu of a dues increase) by allocating $75 of it to the General Fund, and $25 to continue the PLI Campaign Fund. The Minutes of the Board of Trustees meeting of April 20-21, 1988, read as follows:

Resolution O — 1986 House of Delegates' Referral (Dues)

Doctor Cassady noted that the Budget Committee had reviewed Resolution O, adopted by the 1986 House of Delegates. He stated that the Budget Committee and the Executive Committee had thoroughly discussed the dues structure, had noted the importance of continuing efforts in the area of professional liability insurance reform, and had further noted that KMA had reached the end of a five-year dues cycle. Doctor Cassady stated that it was the recommendation of the Budget Committee, and concurrence of the Executive Committee, that dues for Regular, Active members remain at $400, with $25 per member designated for the PLI Fund.

A motion was made, seconded, and carried that the Board of Trustees adopt the recommendation of the Budget Committee and the Executive Committee that dues for Regular, Active members remain at $400 (as established by the 1986 House of Delegates), with $25 per member designated for the PLI Fund, and $375 earmarked for the KMA General Fund.

Some of the financial considerations discussed in the meeting leading to this decision were:

1. KMA is completing the final year of its current five-year dues plan with a current Budget deficit of $328,903.
2. That deficit is now covered by interest generated by our Reserve Fund, but that Fund will be quickly dissolved by ongoing deficits. As a matter of fact, it would be completely eliminated in less than five years.
3. It is KMA policy to maintain a one-year operating budget in reserve, which is approximately what we have today.
4. Without the interest the Reserve Fund generates, our dues within the next five years would need to be $200 more than they are today just to balance the Budget.
5. The Reserve Fund generates income equivalent to that of 750 full dues-paying Active members, so it is essential that it be maintained at the current level to keep dues at a minimum.

In addition, expenses have been authorized from the PLI Fund through the 1990 General Assembly, as we continue our quest to ease the professional liability insurance crisis. The Board of Trustees action was without dissent, and we feel it is essential to maintain fiscal responsibility. We urge concurrence by the House of Delegates.

Legal Trust Fund

Each year a report on the Legal Trust Fund is included in the Chairman's Report. Expenditures were made during this Associational year of $1,652.95, and the Fund's balance is $144,204.27.

The following summary of Board meetings is submitted to assist you in assessing the scope of your Board's activities this year. Complete Minutes of all Board meetings will be provided to Reference Committee No. 1.

SUMMARY OF BOARD MEETINGS

First Meeting, September 17, 1987

Acting as temporary Chairman, KMA Secretary-Treasurer, S. Randolph Scheen, MD, introduced the newly elected members of the Board and the new Officers: Bob M. DeWeese, MD, Louisville, President-Elect; Nelson B. Rue, MD, Bowling Green, Vice President; Larry P. Griffin, MD, Louisville, Trustee, Fifth District; Jerry W. Martin, MD, Bowling Green, Trustee, Sixth District; and William H. Mitchell, MD, Richmond, Trustee, Eleventh District.

The Board elected the Executive Committee members to serve with the President, President-Elect, Vice President, and Secretary-Treasurer for the 1987-88 Associational year. William B. Monnig, MD, Edgewood, was elected Chairman of the Board, and Albert H. Joslin, MD, Owensboro, was elected Vice Chairman. John D. Noonan, MD, Paducah, and Preston P. Nunnelley, MD, Lexington, were named as Trustees-at-large.

It was noted that the KMA Executive Committee members also serve as the Board of Directors of KMA Physicians Services, Inc., (KMA's holding company). The Board also made changes to the Kentucky Foundation for Medical Care Board of Directors in accordance with KFMC's Bylaws, and appointed KMA committees for the 1987-88 Associational year. The Board voted to hold the 1988 Annual Meeting in Lexington, Kentucky.

Second Meeting, December 16-17, 1987

The KMA Board held its second meeting of the Associational year on December 16-17, 1987, and the 1988 Kentucky General Assembly and professional liability insurance were the focus of several reports presented. S. Randolph Scheen, MD, Secretary-Treasurer, reported that Officers and staff had been busy preparing for the 1988 Legislative Session, and Pamela Potter, President of the Auxiliary to KMA, reported that the Auxiliary would host a "Day at the Capitol" in February.

Richard F. Hench, MD, a member of the Kentucky Liability Insurance Task Force, reported that the Task Force had issued its final report containing 35 recommendations. The Board empowered the Legislative and Quick Action Committees to support the Task Force Report in all aspects that are not in conflict with any current KMA policy. The Board also endorsed the application for a grant from the Robert Wood Johnson Foundation to study the no-fault medical malpractice plan, authored by Carl L. Wedekind, Jr.

Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities, noted that KMA would conduct a Legislative Seminar in Frankfort on January 6, 1988, featuring leadership of the Kentucky General Assembly. Doctor Montgomery reported on numerous legislative issues, and the Board voted to oppose a Board of Nursing regulation that permitted ARNPs to encroach into the practice of medicine.

President Donald C. Barton, MD, reported on the AMA Interim Meeting just completed, and the Commissioner for Health Services, Carlos Hernandez, MD, discussed AIDS and other matters of current interest under his jurisdiction.

John Llewellyn, MD, Secretary of the Board of Medical Licensure, reported in some detail on the Board's activities, and a question and answer session followed. Doctor Montgomery was appointed to serve as KMA's representative on an ad hoc committee of the Board of Medical Licensure to propose legislative language on the issue of certification of respiratory therapists.

Bob M. DeWeese, MD, KMA President-Elect, reported on his service as a member of the Advisory Committee to the Peerview, Inc., Board of Directors, and the Board appointed a Peerview Oversight Committee to implement Resolution B (1987). It was noted that other ad hoc committees had been appointed to implement Substitute Resolution P (1987), regarding the KMA election process, and Substitute Resolution G (1987), on professional liability insurors.

The Board accepted the report of a committee that had investigated a complaint received following the election of the Eleventh District Trustee during the September 16 meeting of the KMA House of Delegates.

A Judicial Council statement regarding administrative pressures placed on physicians under cost containment plans was reviewed, and the Board directed that a summary be published in the KMA *Journal.*

James B. Holloway, Jr, MD, Medical Director, Department of Medicaid Services, made a slide presentation regarding the current operation of the Medicaid Program, and staff provided an update on developments in the Medicare Program, including the issue of MAAC determinations.

It was reported that for the second year in a row HCFA intended to release data on hospital mortality rates. Concerns were expressed that the mortality rate data prediction is flawed, that the data would be misleading to consumers, and that mortality is a crude measure of quality.

The Board reviewed a recommendation of the KMA Committee on Medical Insurance and Prepayment Plans for the members' health insurance plan, and voted to retain the current High Option Plan; renew the Low Option Plan with Assurance Plus; and not offer Option 2000. It was further reported that the Committee did not oppose Diagnostic Guidelines in the manner BCBS planned to use them, and was studying proposed changes in UCR Guidelines developed by KMA and BCBS in 1968.

In other reports, it was noted that KMA now has 5,292 members, and that Articles of Incorporation have been drafted for the McDowell Foundation. It was also reported that the Hospital Medical Staff Section had determined that Resolution R, "Inappropriate Requirements for Hospital Staff Membership" (1987), could not be implemented as written, and the Resolution was referred back to HMSS for further consideration.

The Board endorsed Executive Committee recommen-

dations that KMA recognize the existence of the nursing shortage, and directed the Committee to Investigate Changing Trends in Medicine to address the problem.

The next meeting of the Board of Trustees was scheduled for April 20-21, 1988.

Third Meeting, April 20-21, 1988

The KMA Board of Trustees held its third meeting of the Associational year on April 20-21, 1988, at the KMA Headquarters Building in Louisville.

The Board members heard reports from the President, the President of the Auxiliary to KMA, the Secretary of the Board of Medical Licensure, and the Commissioner for Health Services.

The Secretary-Treasurer, S. Randolph Scheen, MD, reported that the Hospital Medical Staff Section would meet on June 16, and would feature an address by James Todd, MD, Deputy Executive Vice President of the AMA. Wally O. Montgomery, MD, Chairman of the Committee on State Legislative Activities, presented a comprehensive report on the recently completed Kentucky General Assembly, which detailed KMA's successes in the area of civil justice/liability reform, House of Delegates' directives, and other health and medical legislation. Doctor Montgomery was presented with a plaque in appreciation for his many hours of service on behalf of the profession.

Several other presentations were also made, including a plaque to Fred C. Rainey, MD, Senior Delegate to AMA, for his work at the AMA level, and a set of bound *Journals* to Editor Evan Overstreet, MD. It was reported that a plaque had also been prepared for Richard F. Hench, MD, in appreciation for his service during the past two years on the Kentucky Insurance Liability Task Force.

The Board members adopted the Budget as proposed for the 1988-89 fiscal year, and further adopted a recommendation of the Budget Committee that the Board recommend to the House of Delegates that dues remain at $400, with $25 per member earmarked for the PLI fund.

A slate of nominees was approved for appointment to the KMIC Board of Directors, and the Board Chairman was authorized to appoint an ad hoc committee to study the selection process of the KMIC Board. Nominees were finalized for submission to the Governor for the Kentucky Board of Medical Licensure, and the Board approved a Resolution for introduction into the 1988 House of Delegates regarding requirements for hospital medical staff membership, which had been modified following referral by the House in 1987. In followup to another Resolution adopted by the 1987 House, it was noted that KMA Officers would meet with the Commissioner of Insurance to discuss concerns relating to managed health care plans.

The Board supported the concept of a Task Force appointed by the Governor to address the nursing shortage, and agreed to appoint a representative to such a Task Force, if one was formed.

Fourth Meeting, August 10-11, 1988

The KMA Board of Trustees held its fourth meeting of the Associational year on August 10-11, 1988, at the KMA Headquarters Office in Louisville. Reports were given by the President, Secretary-Treasurer, Auxiliary President, and Senior Delegate to the AMA, who highlighted actions of the June AMA Annual Meeting. The Secretary of the Board of Medical Licensure summarized activities of that Board for the past year, and the Commissioner for Health Services discussed cuts in the state budget that would affect medical care in Kentucky.

The Board voted approval of the use of funds from the Legal Trust Fund for expenses incurred in a suit regarding confidentiality of peer review, and authorized a $10 voluntary billing for the Fund for 1989. Reports were accepted regarding a number of KMA committees, with details given on specific activities of the Committee on State Legislative Activities, and the Committee on Maternal and Child Health dealing with sex education in schools. The Chairman of the Ad Hoc Committee on Professional Liability Insurance gave an update on the PLI Campaign Plan, and the Board recommended its adoption to the House.

Nominations were made for a physician appointment to the Board of Medical Licensure to be made by the Governor, and an appointment was made to the KEMPAC Board.

The Board discussed Annual Meeting matters, and directed that Resolutions be drafted on the subjects of nursing education, medical services offered by hospitals, and minimal standards of care provided by health care plans. A listing of actions taken by the 1987 House of Delegates was distributed for review of the implementation of each action, noting the same information would be sent to every Delegate as a part of the Board Chairman's Report. The Board also approved a proposal for a Voluntary Medicare Assignment Program for submission to the House of Delegates.

The Board finalized its six ad hoc committee reports, and reviewed the Reports of all KMA committees with recommendations to the House of Delegates for specific action on several Reports. The next meeting of the Board was scheduled for September 25, 1988.

Executive Committee

The eight physician Officers and Trustees who serve on the Executive Committee meet between meetings of the full Board and oversee the day-to-day operations of KMA. This effort, their dedication, and their contributions to Medicine are exemplary. This past year the Executive Committee met on numerous occasions and kept a finger on the pulse of KMA as we traveled through a very busy year, possibly the Association's busiest ever.

Four of the Executive Committee members (President,

President-Elect, Chairman of the Board, and Secretary-Treasurer) serve as the Quick Action Committee. Not only does this group meet on a spur-of-the-moment basis to make policy decisions on matters of an urgent nature, but it gathers in Frankfort weekly during the Kentucky General Assembly to guide KMA's legislative program. The commitment made and demonstrated by these Officers with whom I served was unbelievable. The time and counsel provided by such physicians constitute one of the Association's greatest assets.

Young Physicians Steering Committee

During the Associational year, the Board of Trustees appointed a Young Physicians Steering Committee, chaired by Donald J. Swikert, MD, of Florence. A report on this new activity, which we feel will be most beneficial as we plan for the future, is appended to this Report.

Ad Hoc Committees

In addition to our regular committees, this year there were six ad hoc committees of the Board. They are the Ad Hoc Committees on:

(1) Professional Liability Insurance; (2) Indigent Medical Care; (3) KMA Election Process; (4) Foreign Medical Graduates; (5) KMIC Board Election Process, and (6) Professional Liability Insurors.

The Ad Hoc Committee on Indigent Medical Care was appointed last year in response to requests from the State Legislature. An indigent care proposal was developed and adopted by the House last year, and submitted to the legislative committees of jurisdiction as KMA's formal proposal.

No legislation was passed this year and the primary concern relating to indigent care remains that of financing. Our appreciation is extended to this Committee's Chairman, Russell Travis, MD, who testified for us on numerous occasions.

The Ad Hoc Committee on the KMA Election Process was appointed as a result of last year's Substitute Resolution P, which read: "Resolved, that an ad hoc committee be appointed to study the system whereby nominees for KMA Officers and Delegates are chosen." The Committee drew two conclusions and the Board accepted the Committee's report and its motion which reads:

> . . . That the current process be strengthened by better publicizing the Nominating Committee selection process and enlisting the help of the Trustees in reminding the physicians in their Districts of the offices in which elections are to take place, and encouraging participation from those Districts; and further, that county societies be encouraged to nominate candidates and send their names to the Headquarters Office by early August; and further, that the Nominating Committee become more active in presenting one or more nominees for each office.

In addition, the Committee felt the KMA Bylaws were difficult to interpret in addressing the conduct of those who wish to seek an office in KMA. The Board agreed and referred Chapter IV, Section 5, of the Bylaws to the Committee on Constitution and Bylaws for study and clarification. That section now reads: "Any member may make known his availability for any office within the gift of the Association. However, it would be regarded as unseemly for any member to actively campaign for his own election." The Board appreciates the fine efforts of this Committee and its Chairman, Don R. Stephens, MD.

The Ad Hoc Committee on Foreign Medical Graduates (FMGs) met to consider licensure requirements and procedures for FMGs. A representative from the Kentucky Board of Medical Licensure met with the Committee and explained that U.S. applicants are required to complete one year of postgraduate training, while FMGs are required to complete three years. This regulation was implemented by the Licensure Board to guarantee a standard of training for all Kentucky physicians and to assure competency by imposing U.S. training requirements. The Committee will continue to encourage active participation of FMGs in organized medicine through appointments to committees, election of offices, etc. The Committee on FMGs plans to continue its work with the addition of at least one member.

The Ad Hoc Committee for the KMIC Board Election Process was appointed at the April 1988 Board meeting to formalize the nomination and election process of KMIC Board members by the KMA Board of Trustees. The Committee's report was approved by the Board, and this new process highlighting a Nominating Committee, terms of Directors, and improved communications is noted below, and is being put into effect:

1. Nominating Committee
   - A. A Nominating Committee will be established and composed of three (majority) KMA Board members and two KMIC Board members. KMA's members of the Committee will be appointed by the Chairman of the KMA Board and KMIC will appoint its own two members.
   - B. The Nominating Committee, in selecting its nominees for the KMIC Board, will take into consideration risk categories (high and low), geographic location, age, and the current KMIC policy on its Board of Directors as reviewed by the KMA Board. Further, all physician members of the KMIC Board of Directors must be insured with KMIC.
   - C. After the Committee's appointment, and having knowledge of the vacancies to be filled on the KMIC Board, the Committee will have an opportunity to seek qualified candidates by various means. This will include communicating with the KMA Board of Trustees and other in-

dicated sources to encourage submission of names.

D. All proposed nominations should be in the Committee's possession no later than March 1. After making its final selections, the Committee will report its slate of one person per slot available to the KMA Executive Committee at its April meeting (sometime late March). The Executive Committee will then convey the Nominating Committee slate to the KMA Board of Trustees at its April meeting.

E. Recognizing that on occasion there would be retiring Board members who have special expertise, and that KMIC should continue to have that expertise available to its Board, it is recommended there be added "no more than" two ex-officio, nonvoting positions for such retiring Directors that could be filled by vote of the KMIC Board. (Two positions would be available but not necessarily always occupied.)

II. Terms Of Directors

The terms of KMIC Directors would be for three years each and limited to no more than three (3) consecutive terms. Terms would be staggered so that one-third (⅓) of the Directors' terms would expire each year, at which time the Directors would be reelected or replaced on the Board of Directors.

III. Improved Communications

As a lack of communication is the root of many misunderstandings, communication should be improved and maintained to the fullest extent possible between the KMA and KMIC Boards by requesting that KMIC, through a physician KMIC Board member and a staff member, report all KMIC developments at each regular meeting of the KMA Board of Trustees, and at other special meetings upon request.

The KMA Board of Trustees believes this method of nomination and election and increased communication will be beneficial to all concerned. Our thanks are extended to its Chairman, President Donald C. Barton, MD.

The Reports of the Ad Hoc Committees on Professional Liability Insurance and Professional Liability Insurors are being submitted in detail and are appended to this Report.

An additional addendum is Special Report A of the Board on a Voluntary Medicare Assignment Program. In addition, in keeping with a request of the 1986 House of Delegates, also attached is a summary of the implementation efforts taken during the year on last year's House of Delegates actions.

Once again, I want to thank each member of the KMA staff, the members of the Board of Trustees, committees, and all of my colleagues for the outstanding assistance and support I received this year. I can think of no better learning seat to strengthen one's appreciation of organized medicine than as Chairman of the Board. Thank you for providing me that opportunity.

William B. Monnig, MD
Chairman

RECOMMENDATIONS:

1. The Board of Trustees urges concurrence by the House of Delegates with the Board's action on reallocation of dues.

Report of the Ad Hoc Committee on Professional Liability Insurors

Addendum to the Report of the Chairman, Board of Trustees

The Ad Hoc Committee on Professional Liability Insurors met twice: on January 6, 1988, at the Capital Plaza Hotel in Frankfort, and on July 20, 1988, at the KMA Headquarters Office in Louisville.

At the first meeting, James O. Wood, Actuary of Tillinghast, Nelson, & Warren, presented an informative session about medical liability insurors and the general principles involved in pricing premiums. At that time, the Committee elected to await a possible report by Tillinghast to be completed in March to compare financial data of various companies writing medical liability in this country. When it was learned the study could not be completed by early June, the Committee elected to meet with Leroy Morgan, Commissioner of Insurance for the Commonwealth of Kentucky, and Meredith Loeb, Vice President of an investment advisory company.

This meeting on July 20 featured presentations by Commissioner Morgan; Wendell Clark, Director of Financial Standards; and Chuck Ziedler, Director, Property and Casualty Division for the Department of Insurance. They provided us with a list of all insurors writing medical malpractice insurance in the Commonwealth, and informed us of the minimum standards which must be met by any company seeking to write medical liability insurance in Kentucky.

They also told us of the competitive rate-setting principle in Kentucky which requires all companies to furnish the Commissioner with their rates, but encourages competition in an effort to make insurance both available and less expensive.

In the discussion that followed, the Commissioner and his staff taught us about the principles involved in the evaluation of insurance companies. With the use of data available from other states in which each company writes insurance, as well as the national clearinghouse, they are able to keep score on performance by the IRIS scale. None of the above

means that they have the total ability to predict infallibly the future solvency of any company. It should be noted, however, that Kentucky ranks in the top 15 states as far as the performance of the Insurance Commissioner's office in low numbers of insolvencies of insurance companies.

Ms. Loeb then made a presentation about the ability of her company, (a subsidiary of Lincoln National, the largest reinsuror in the world), and the possibility of evaluating the solvency of various liability insurance companies for interested parties.

The Committee members then met alone and decided the following:

1. There is no sure way to predict solvency of an insurance company. One large problem is the reporting of Claims Incurred But Not Reported. Over a period of years, later reports will yield a tendency of any company to minimize this figure. Thus, the Insurance Commissioner's office may be able to predict impending trouble and take action when this tendency appears.

2. At the present time, the Committee does not feel an independent study is desirable, since there is pending litigation to require the Commissioner of Insurance to restudy the application of at least one major medical liability insuror.

Charles C. Smith, Jr, MD
Chairman

Recommendations, Reference Committee No. 1:

Reference Committee No. 1 reviewed the Report of the Chairman, Board of Trustees, along with its Recommendation No. 1 concerning reallocation of dues. Reference Committee No. 1 recommends that Report No. 5 be filed and Recommendation No. 1 be adopted.

Report of the Kentucky Physicians Care Operating Committee

The Kentucky Physicians Care Operating Committee met once this year with your Chairman and staff being involved in some aspect of the program on a daily basis throughout the year.

As this report is being written, the Kentucky Physicians Care project is starting its 42nd month of operation. During that time, 58,473 individuals have been certified eligible for the program and 24,293 referrals have been made, which we estimate resulted in over 96,000 physician encounters. This latter figure is estimated because, in most cases, once a patient is seen by a participating physician, he or she tends to continue seeing that physician and, as a result, does not continue to call the toll free number.

The Headquarters Office continues to receive telephone inquiries and requests for referral. Over 53,000 calls have been made to the toll free number since the program began in January 1985.

The participation and support of the physicians in Kentucky continue to be excellent. Our current level of participating physicians is 2,299. Thus, more than half of the estimated 4,200 physicians who are actively practicing medicine in Kentucky are participating in Kentucky Physicians Care.

The Committee wishes to particularly recognize the continuing support of primary care physicians who remain the initial contact point for the vast majority of referrals made through the program. The contribution made by these men and women is incalculable, and we are very appreciative of their efforts on behalf of the KPC patients and the medical profession in Kentucky.

The Kentucky Health Care Access Foundation continues as the primary funding source for the program. The Foundation underwrites the cost of the toll free telephone lines, two full-time employees, and a third part-time person hired on an as-needed, temporary basis. The financial contribution made by the Foundation since the onset of the program through March 31, 1988, has been $223,405.14.

KMA continues to provide space at the Headquarters Office, telephone equipment, supplies, furniture, computer time and equipment, postage, and KMA staff involvement as needed.

The Kentucky Dental Association is in the process of implementing the Kentucky Dental Care program, using the same guidelines as the KPC program, whereby KPC eligible patients will be referred to participating dentists for initial evaluation and pain relief at no charge.

The Foundation is continuing its discussions with the Kentucky Pharmacists Association, so they might play a more formal role in the provision of services to the people served by KPC and the Fair Share program. We are hopeful those discussions will be productive.

The Cabinet for Human Resources has been extremely cooperative during the course of the project. Roy Butler, Commissioner for Medicaid Services, and Janie Miller, Deputy Commissioner for Medicaid Services, have given a considerable amount of time and effort to the program, as have the 1,000 field workers in the 120 county CHR offices across the state.

We feel that the Kentucky Physicians Care program, by any measurement, has been successful. It has provided a way for a significant number of poor people to gain access to needed medical services. The program has put Kentucky physicians in a positive light with the general public. It has given us credibility with the Legislature. Kentucky has the only statewide effort we are aware of that has actually *done something* about providing health services to its indigent population.

The Arkansas Medical Society is considering the implementation of a plan similar to ours, and Kentucky's program was recently recognized in the inaugural speech of James E.

Davis, MD, AMA President, as a way of serving those at, or below, the poverty level.

However, the program is not, nor was it ever intended to be, anything other than temporary. It was set up as a formal means of providing a point of access to care and of collecting data on the medical status of the indigent population in Kentucky. The question before the House is, how long can KMA continue to operate the program on a voluntary basis? The cost of the program to KMA has not been extraordinary, but it has not been inexpensive. The number of total participating physicians has remained fairly stable, but there are areas with high numbers of eligible patients and very small numbers of participating physicians, especially primary care physicians. There are several areas of the state with very high patient/physician ratios and those physicians have carried the load in terms of patient care since the program began. The number of eligible patients varies depending on the amount of publicity the program is given from time to time. Even with those facts in mind, the Committee believes there is reason to continue the program through the end of 1989.

Therefore, the Committee suggests that KMA continue the Kentucky Physicians Care program through December 31, 1989, contingent on:

1. Program funding being continued, as appropriate, by the Kentucky Health Care Access Foundation, with KMA contributing in-kind services as done in 1985, 1986, 1987, and 1988;
2. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility, as is currently being done;
3. The Kentucky Hospital Association continuing its Fair Share program as currently operated;
4. The Kentucky Health Care Access Foundation continuing to vigorously encourage the active participation of all other health care delivery and/or financing organizations in Kentucky Physicians Care or the Fair Share program, as may be appropriate; and
5. The Kentucky Health Care Access Foundation making Kentucky legislators aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

The Board of Trustees referred the issue of developing a voluntary Medicare assignment program to the Committee this year. A plan was developed and presented to the Board of Trustees and appears as a part of the Board's Report as Special Report A.

Many people help make the Kentucky Physicians Care program a reality. Participating physicians and their office staffs are the key people in this project, and the Association is very appreciative of their efforts. The KPC staff members continue to be committed to this project and often make an extraordinary effort to resolve nonroutine problems. The Committee is grateful for their loyalty and dedication. Finally, I want to thank the members of the Operating Committee who have made themselves available since the program began.

Russell L. Travis, MD
Chairman

RECOMMENDATIONS:

1. The Committee recommends that KMA continue the Kentucky Physicians Care program through December 31, 1989, contingent on:
   A. Program funding being continued, as appropriate, by the Kentucky Health Care Access Foundation, with KMA contributing in-kind services as done in 1985, 1986, 1987, and 1988;
   B. A continuing commitment from the Cabinet for Human Resources to evaluate program applicants for eligibility, as is currently being done;
   C. The Kentucky Hospital Association continuing its Fair Share program as currently operated;
   D. The Kentucky Health Care Access Foundation continuing to vigorously encourage the active participation of all other health care delivery and/or financing organizations in Kentucky Physicians Care or the Fair Share program, as may be appropriate; and
   E. The Kentucky Health Care Access Foundation making Kentucky legislators aware of the plight of those ineligible for Medicaid assistance solely because they do not meet the confusing and arbitrary requirements of the Medicaid program, while working to broaden the societal financial obligation necessary to provide care to those in need of such assistance.

Recommendations, Reference Committee No. 1:

Reference Committee No. 1 reviewed the Report of the Kentucky Physicians Care Operating Committee along with its Recommendation that KMA continue the Kentucky Physicians Care Program through December 31, 1989, with certain contingencies. The Reference Committee heard testimony about the Kentucky Physicians Care Operating Committee which included concern that the Program, originally designed to care for short-term illnesses, now includes many patients with long-term illnesses who may be poorly served by the necessity to reapply to the Program.

Reference Committee No. 1 recommends that this Report and its Recommendation be adopted.

Reference Committee No. 1 also recommends that the Board of Trustees reevaluate the goals of this Program in view of perceived problems in delivering continuous high-quality care for those patients with long-term illnesses.

Report of KMA Physicians Services, Inc.

KMA Physician Services, Inc., the Association's only wholly-owned subsidiary, serves as a holding company to its only wholly-owned subsidiary, the KMA Building Corporation. The KMA Executive Committee serves as the Board of Directors for both of these corporations.

The purpose of the Building Corporation is to collect rental funds, pay operating expenses, and maintain a contingency fund to pay any unanticipated expenses for the most recent addition to the KMA Headquarters Building.

There is nothing untoward to report concerning the transactions of the Building Corporation and KMA Physician Services, Inc., this year, and we anticipate a continuing smooth operation as the order of business in the future.

William B. Monnig, MD
Chairman

Recommendations, Reference Committee No. 1:

Reference Committee No. 1 reviewed Report No. 11, Report of the KMA Physicians Services, Inc., which serves as a holding company for the KMA Building Corporation.

The Committee recommends that this Report be filed.

The Reference Committee also recommends that a more succinct, identifiable accounting of the operations of KMA Physicians Services be made available to this House of Delegates to better define the financial activities of this entity.

Resolution D

Premium Discounts to Faculty
Jefferson County Medical Society

WHEREAS, medical school faculty members are pursuing the private practice of medicine with unprecedented vigor, and

WHEREAS, the Kentucky Medical Insurance Company continues to offer a 25% premium discount to medical school faculty members on the presumption of their greatly reduced proportion of private practice and attendant lower risks, now therefore be it

RESOLVED, that the Kentucky Medical Association again question the policy of the Kentucky Medical Insurance Company granting premium discounts to university faculty members.

Recommendations, Reference Committee No. 1:

Reference Committee No. 1 reviewed Resolution D, Premium Discounts to Faculty, submitted by Jefferson County Medical Society. There was considerable testimony concerning this Resolution.

The Reference Committee recommends adoption of Resolution D.

Resolution E

Electronic Voting at AMA Meetings
Jefferson County Medical Society

WHEREAS, much time is lost during deliberations of the AMA House of Delegates when the Speakers are unable to ascertain the outcome of a voice vote and tellers are required to count and report their findings, and

WHEREAS, every five-minute delay for these purposes wastes more than 35 person-hours among the 422-member House of Delegates, now therefore be it

RESOLVED, that the Kentucky Medical Association encourage the American Medical Association to study the cost and feasibility of implementing an electronic voting system to facilitate the activities of the AMA House of Delegates.

Recommendations, Reference Committee No. 1:

Reference Committee No. 1 reviewed Resolution E, Electronic Voting at AMA meetings, submitted by Jefferson County Medical Society.

Reference Committee No. 1 recommends adoption of Resolution E.

Mr. Speaker, Reference Committee No. 1 recommends the adoption of the Report of Reference Committee No. 1 as a whole.

Mr. Speaker, I want to personally thank the members of Reference Committee No. 1 who worked hard to assist this House of Delegates in these matters. Members of the Committee are Henry R. Bell, MD, Elkton; John W. Collins, MD, Lexington; John D. Doyle, MD, Louisville; and Don R. Stephens, MD, Cynthiana. I would also like to take this opportunity to thank Jeanette Thompson for her help and assistance in the preparation of this report.

REFERENCE COMMITTEE NO. 1

Charles F. Allnutt, MD, Covington, Chairman
Henry R. Bell, MD, Elkton
John W. Collins, MD, Lexington
John H. Doyle, MD, Louisville
Don R. Stephens, MD, Cynthiana

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 2

Russell H. Davis, MD, Pikeville, Chairman

Reference Committee No. 2 considered the following Reports and Resolution:

13. Report of the Scientific Program Committee
14. Report of the Scientific Exhibits Committee
15. Report of the Continuing Medical Education Committee
16. Report of the Council for Continuing Medical Education
17. Report of the Cancer Committee
18. Report of the Emergency Medical Care Committee
19. Report of the Physician Manpower Committee
20. Report of the Interspecialty Council
21. Report of the Hospital Medical Staff Section
    Resolution A — Inappropriate Requirements for Hospital Medical Staff Membership (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 2 reviewed the following items and recommends they be filed by consent of the House, without discussion:

13. Report of the Scientific Program Committee — filed
14. Report of the Scientific Exhibits Committee — filed
15. Report of the Continuing Medical Education Committee — filed
16. Report of the Council for Continuing Medical Education — filed
17. Report of the Cancer Committee — filed
20. Report of the Interspecialty Council — filed
21. Report of the Hospital Medical Staff Section — filed

Mr. Speaker, Reference Committee No. 2 recommends adoption of the Consent Calendar as a whole.

Report of the Scientific Program Committee

"What's New in Cancer Therapy?" was selected by the Scientific Program Committee as the overall theme for the 1988 KMA Annual Meeting Scientific Program. Presentations on the morning sessions will focus on issues relating to the overall theme from the perspective of the various specialties participating in the Meeting. A portion of the Wednesday morning session will feature a look at "The Ethics of Death and Dying" from the medical, legal, ethical and media viewpoints. The Committee members and specialty society presidents, and/or program planners, have gone to great lengths to bring in some of this country's outstanding speakers, and we are hopeful that the membership will find their presentations useful.

The Scientific Program was planned last fall and a meeting was held in December with the presidents and/or representatives of the 22 specialty groups, which will participate in the Annual Session, to discuss their part in planning the Scientific Program. Specialty group scientific programs held in conjunction with the General Sessions have proven invaluable, and we feel provide an excellent contribution to the continuing medical education of the membership. I personally appreciate the excellent cooperation the Committee has had from the specialty societies in planning the overall Meeting.

The 1988 KMA Annual Meeting will be held September 26-29 in Lexington, with all general scientific programs being held in the Lexington Center. All specialty group meetings will be in the Lexington Center and in the Hyatt Regency Lexington Hotel.

In follow up to a request from the President's Report last year to consider holding the Meeting over a weekend, staff surveyed exhibitors, specialty group presidents, and physicians attending the 1987 Annual Meeting to get some feedback on reformatting the meeting. The overall results were that the majority of respondents wanted to continue the Meeting in its current format. The Committee did not feel any further consideration of a new Meeting format should be made at this time.

This year the specialty groups will again follow basically the same format as the past couple of years with meetings being held on Tuesday, Wednesday, and Thursday afternoons.

This year's Annual Meeting was again certified for AMA Category 1 continuing medical education credit and was also approved for CME credit by several specialty societies.

We urge the membership to visit the Technical Exhibit area during the course of the Meeting. We feel it is a most worthwhile and meaningful adjunct to the formal Scientific Program and offers members the opportunity to discuss new products and become familiar with new equipment free from the interruptions and distractions of the office or hospital.

I am very grateful for the efforts of those who have assisted in the formation of this program, particularly the Program Committee, specialty group presidents, and program chairmen. I would especially like to thank Martha Coombs and Bill Applegate, whose outstanding efforts help make the programs the tremendous success they always are.

Suggestions for future programs are always welcomed by the Scientific Program Committee.

James A. Baumgarten, MD
Chairman

Report of the Scientific Exhibits Committee

The Scientific Exhibits Committee is pleased to report to the KMA House of Delegates that there were 10 scientific exhibits at the 1987 Annual Meeting. The exhibits were educational and informative and attendees had many favorable remarks on the quality of exhibits. Participating physicians were awarded certificates of excellence and certificates of appreciation. We urge members who have something to offer in terms of new procedures or techniques to consider developing an exhibit for the KMA Annual Meeting and sharing it with their peers.

The Scientific Exhibits Committee conducts all activities

by telephone or correspondence. Submitted exhibits are reviewed by individual members of the Committee for relevance and accuracy. In addition, we urge that exhibits be attractive and sponsors be available for discussion with the attendees at the KMA Annual Meeting.

We look forward to continued service to the Association and welcome suggestions for improvement in quality and numbers of exhibits.

Richard A. Kielar, MD
Chairman

Report of the Continuing Medical Education Committee

A number of activities were generated by the Committee on Continuing Medical Education this year and these activities have increased considerably toward the end of the Associational year.

The issue of status as an accreditor of continuing medical education has been in question for some time. The Committee has held some concern about a revised accreditation process and documentation required by the Accreditation Council on Continuing Medical Education (ACCME). This year the process was finalized to the satisfaction of the Committee, and the accreditation activities have resumed.

In July, the Committee met with a consultant from the ACCME, Frances Maitland, who was most helpful in advising and counseling on KMA's process. While a number of revisions still need to be made, improvements are occurring as a result of Ms. Maitland's visit. The Committee completed its document revision, and all reports and records used in the process have been formally adopted.

Institutions were contacted to determine their ongoing interest. Those institutions which responded affirmatively were provided with the new documents, and survey visits will be scheduled as completed applications are returned. Other institutions which were previously accredited but expressed no interest in upgrading the process have been recontacted to affirm their status.

Because of the changes that have occurred in the process, the Committee is planning to schedule a seminar in the fall for chairmen of CME committees, institutions seeking accreditation, and directors of medical education who are employed by those institutions. This seminar will serve as a forum to discuss the accreditation process and the new application forms.

Throughout this period, relations were strengthened with the Departments for Continuing Education of the University of Louisville and the University of Kentucky, and representatives of both those offices have been quite helpful in assisting KMA's efforts. It is hoped that this liaison will continue and grow.

Continuing from years past, the Committee has considered the issue of CME programs relating to risk management and quality assurance. Because KMA's provider status for CME is undergoing review, sponsored programs could not be offered this year; however, informal contact has been made with both medical schools, the Board of Medical Licensure, and the Kentucky Medical Insurance Company to further consider this effort and to try to produce concrete, worthwhile efforts for the coming year. Contacts with other liability insurors to this point have not been fruitful.

As the accreditation process begins its renewal, it will require the cooperation of physicians at all levels. The Committee urges any member who has an interest in CME from an institutional perspective to contact the Committee and assist in these efforts.

As Chairman, I would like to thank members of the Committee for all their help this year.

James E. Redmon, Jr, MD
Chairman

Report of the Council for Continuing Medical Education

The Council for Continuing Medical Education is the CME provider arm of KMA. As indicated in last year's report, the primary effort this year was to complete an application for provider status for CME from the Accreditation Council on Continuing Medical Education (ACCME).

Previously KMA had served as both a provider and accreditor of CME, but process changes have required KMA to apply directly to the ACCME as a provider, separate from its accrediting activities.

As the authorized accrediting agency for the state, KMA is required to undergo an intensive review as compared with that which an individual institution might expect. This year the provider application was completed and also submitted to the ACCME. No survey by the ACCME has yet been scheduled, and it is anticipated that the survey may not take place until the first part of 1989. At that time, and upon successful acquisition of provider status, KMA will expand the programs it does provide, including those relating to risk management and joint sponsorship of CME offerings with other organizations and institutions. At that point, KMA will be able to resume its CME mission of helping to ensure the availability of quality programs for its members.

To assist in this effort, any member who is involved with CME within a specialty group or institution is urged to contact the Council and provide assistance in reviewing programs.

As Chairman, I would like to thank each of the Council members for their valued help this year.

James A. Baumgarten, MD
Chairman

Report of the Cancer Committee

The KMA Cancer Committee met once during the Associational year with major discussion focusing on the review of the breast cancer booklet, *Breast Cancer: Treatment Options*, and activities of the Kentucky Division, American Cancer Society.

As most physicians know, the 1984 Kentucky General Assembly passed legislation requiring that the booklet, *Breast Cancer, Treatment Options*, be presented to women with breast cancer. The law required that Directors of the Ephraim McDowell Cancer Network and the J. Graham Brown Cancer Center present a booklet to the Cabinet for Human Resources for printing and mailing to Kentucky physicians. As noted in several mailings to KMA membership, the law does not provide penalties for noncompliance, but failure to provide the written information may preclude a patient from giving her informed consent to the treatment undertaken, resulting in liability in a subsequent malpractice action. Failure to comply with a statute promulgated to protect citizens can result, under some fact situations, in a directed verdict of liability for a plaintiff.

The Committee strongly urges physicians to obtain and provide copies of the pamphlet to all patients under treatment for any form of breast cancer. The Committee is concerned that too many physicians are still unaware of this statute, and it was recommended that periodic notices be published through the KMA *Journal* and the "Communicator" on the availability of the booklet. A copy of the second edition of the cancer booklet was mailed to each Committee member in June 1988 after the Cancer Committee meeting.

Wayne Miller, Executive Director of the Kentucky Division of the American Cancer Society, reported that last year a mammography screening program was developed in Kentucky. The primary purpose of the program was to offer low-cost mammographies for a specified period of time to bring women into the system and encourage them to make mammographies a normal part of their medical routine.

Some concern was expressed by the Committee over this program because of the possibility that no follow-up examination would be conducted. As was pointed out, mammographies are only 85% accurate in detecting cancer and need to be used as part of a complete breast examination.

Another area of Committee activity concerned smoking-related cancer which accounts for one-third of all cancers in the United States. Last year the Cancer Committee recommended to the KMA House of Delegates an immediate restriction of smoking in hospitals to closed, well-ventilated areas within Kentucky hospitals, concomitant with public education toward the goal of a smoke-free environment.

The Committee also reviewed the status of Resolution A concerning a restriction of smoking in hospitals which was adopted by the 1987 KMA House of Delegates. The Resolution was referred to the KMA Hospital Medical Staff Section which sent a letter to the Kentucky Hospital Association asking for its help in carrying out the recommendation. It was pointed out by the Committee that most hospitals have designated nonsmoking areas, and it was suggested that an article be put in the KMA *Journal* describing how certain hospitals have designed and implemented their no-smoking policies.

Many items of concern to the Cancer Committee were not addressed this year because of poor attendance at the Committee meeting. The Committee appreciates the opportunity to be of service to the Association and looks forward to working with the Board of Trustees and the membership in the future.

P. Raphael Caffrey, MD
Chairman

Report of the Interspecialty Council

The KMA Interspecialty Council did not meet this Associational year. The Council was not assigned any specific Resolutions or Reports from the House of Delegates or Board of Trustees. We communicated with Council members on two occasions asking for suggestions. Many of the Council members were actively involved in the 1988 legislative effort.

During the Kentucky General Assembly, issues directly affecting particular specialty groups were referred to the society president for comments and recommendations. KMA leadership has extensively involved specialty groups, particularly in the professional liability insurance campaign. The Ad Hoc Committee on Professional Liability Insurance is composed of members of all specialty groups who have direct input into legislative recommendations.

The KMA Specialty Services Office provides administrative and secretarial assistance to all specialty groups at a very minimal fee. We urge Officers and Board members of specialty groups to contact the KMA Specialty Services Office and learn about available services.

On behalf of the Committee, we thank the Board of Trustees and KMA members for providing a conduit to individual societies with an opportunity to discuss concerns and seek common ground. Remaining united, despite our differences, is vital to the survival of the profession and our ability to defend patient rights and quality care issues. A fractured profession is an open door to adversaries and a sign of weakness to the legislative and bureaucratic branches of government.

Paul J. Parks, MD
Chairman

Report of the Hospital Medical Staff Section

The Hospital Medical Staff Section (HMSS) has been in

existence for four years, having been established in October of 1984. The medical staffs of 78 hospitals have elected a representative to the KMA-HMSS. With 120 hospitals in Kentucky eligible, we are encouraged by our current membership. Efforts will continue to secure representatives from the remaining hospitals.

Terms for representatives to the HMSS are now three years rather than the one-year term originally established. This change was approved by the Board of Trustees in 1987, at the request of the HMSS, to provide continuity for a more effective Hospital Medical Staff Section. All medical staff presidents were notified of this change and asked to elect a new representative, or reelect the current representative for a three-year term, beginning with this year's HMSS annual meeting held on June 16.

This year's meeting featured several timely subjects. Rufus K. Broadaway, MD, of Miami, Florida, a member of the AMA Board of Trustees, spoke on quality assurance. Doctor Broadaway has been active with the Joint Commission on Accreditation of Healthcare Organizations, currently serving as an AMA Commissioner to the Joint Commission. He presented information on the importance of quality assurance and AMA's role in that endeavor, stating that at the 1987 AMA Annual Meeting the House of Delegates adopted a statement that reiterated its commitment to quality assurance. Doctor Broadaway noted that AMA's strategy for fostering quality measurement, evaluation, and assurance consists of four major elements: establishing a quality information activity, appraising the major quality evaluation systems, developing quality assurance protocols, and continuing to develop and advocate policy. To accomplish this commitment, AMA recently established an Office of Quality Assurance and, in addition to the continuation of AMA's previous efforts in this area, several new programs are underway, to include quality assurance case studies and guidelines for establishing quality assurance programs.

Russell Travis, MD, Lexington, KMA Delegate to the AMA and Chairman of the Kentucky Physicians Care Operating Committee, presented information on relative value scales and his experience in dealing with this issue. Doctor Travis explained that two years ago Congress, in its quest to find ways to reduce continually rising Medicare costs, mandated that a Resource-based Relative Value Scale (RB-RVS) study for physician services be conducted. Harvard University's School of Public Health was asked to do this study, with the final proposal scheduled for submission to the Secretary for Health and Human Services in 1988. The HHS Secretary is required to report to Congress by July 1, 1989, on the development of an RVS, including possible implementation of a payment system based on an RVS by January 1, 1990.

The heart of the new physician reimbursement system would be an RVS based on the resource costs of providing physician services, to include the intensity, complexity, and time involved in providing a particular service, physician overhead, and the costs involved in advanced professional training. Doctor Travis noted he had been involved in the RVS study serving on a technical consultant group as a neurosurgical representative. He recapped some of the working sessions, noting the tremendous volume of paperwork the participants were asked to review in a very limited amount of time, and commented on the proposed values for a number of procedures.

AMA has played a role of "subcontractor" in the study by supplying information, but no endorsement for implementation has or will be given by AMA until a thorough review of the results has been conducted by that Association in consultation with the medical specialty societies. Such review will include such issues as gradual implementation, monetary conversion factors to change the RVS to physician payments, updating mechanisms, and specialty and geographic variations.

Ardis Hoven, MD, Lexington, who served as Chairman of the 1986-87 KMA Ad Hoc Committee on the Development of AIDS Guidelines, presented medical facts and documented epidemiologic statistics on Acquired Immunodeficiency Syndrome, the threat it poses to our population, and the growing concern of the state's citizenry with the spread of this fatal disease. Doctor Hoven spoke about the laws and regulations currently in effect in Kentucky to deal with AIDS and other communicable diseases, and noted that a number of legislative proposals dealing with AIDS were introduced during the 1988 session of the Kentucky General Assembly. Lack of factual information and fear about AIDS on the part of the general public has prompted the Federal Government to prepare and mail to each household in the United States a pamphlet describing the disease, how it is transmitted, and how it can be avoided.

Wally O. Montgomery, MD, Paducah, Chairman of KMA's Committee on State Legislative Activities and Ad Hoc Committee on Professional Liability Insurance, provided a comprehensive report on the 1988 Kentucky General Assembly noting that a total of 1,429 pieces of legislation were introduced. KMA reviewed all legislative proposals and followed 125 bills, some of which were more closely scrutinized than others.

Passing legislation to relieve the professional liability insurance crisis was the Association's number one priority during the 1988 Legislative Session, and Doctor Montgomery noted the passage of House Bill 551 dealing with Civil Justice Reforms, and House Bill 552, Insurance Regulatory Measures, as well as House Concurrent Resolution 62, calling for Rule Changes in the Court System. While not an overnight solution, it is hoped these measures will provide some long-term improvement in this area. Unfortunately, House Bill 550, Constitutional Amendment to limit awards in malpractice cases, failed to pass. House Bill 558, which Doctor Montgomery noted was a no-fault or Workers' Compensation approach to medical liability, was not overwhelmingly received by members of the General Assembly, and the proposal to reduce the statute of limitations for minors saw little support by legislators.

Doctor Montgomery also reviewed other legislative issues and proposals of interest to KMA, noting that physicians throughout the state responded to KMA's appeals for assistance with their local legislators through telephone, letter, and personal contacts. That response played a large part in KMA enjoying an extremely successful Legislative Session.

Burns Brady, MD, a member of KMA's Committee on Impaired Physicians, spoke on the Committee's work in helping physicians who have become impaired by alcohol or drug dependency. Doctor Brady detailed some personal experiences that led to his interest in and dedication to the work of the Impaired Physicians Committee, and explained the steps the Committee takes in rehabilitating a physician from the point of initial contact to seeing the individual again as a productive citizen and physician. The Committee also works with the families of impaired physicians because of the problems family members experience and their involvement in the "healing process." Doctor Brady urged members of the HMSS to contact the Committee on Impaired Physicians whenever they suspect that a member of their medical community might have a problem.

During the June meeting of the HMSS, elections were held for positions on the HMSS Steering Committee for the 1988-89 Associational year, in compliance with the Bylaws of the Section. Elected to these positions were:

Chairman:	Donald J. Swikert, MD, Florence
Vice Chairman:	Earl P. Oliver, MD, Scottsville
Secretary:	Roderick H. MacGregor, MD, Bedford
Delegate:	David R. Watkins, MD, Louisville
Alternate Delegate:	Harold L. Bushey, MD, Barbourville
Members at Large:	R. J. Phillips, Jr, MD, Owensboro
	James G. Kuhns, MD, Louisville

Several matters from the 1987 House of Delegates were referred to the HMSS, and these were reviewed at the June meeting, having previously been dealt with by the HMSS Steering Committee at meetings on November 19, 1987, and March 3, 1988.

Resolution A and Cancer Committee Report called for KMA to seek appropriate restriction of smoking in Kentucky hospitals "to areas where there would not be cross contamination of smoke exposing nonsmokers, concomitant with public education towards the goal of a smoke-free environment."

The Steering Committee checked with the Kentucky Hospital Association, which reported it has no formalized policy, but believes most of its member hospitals have designated smoking areas. AMA's policy urges physicians to take the lead in promoting the development of nonsmoking policies and programs, and the AMA Council on Scientific Affairs has developed guidelines with respect to smoking in hospitals. The Steering Committee further learned that the Commonwealth of Kentucky has no policy regarding smoking in public buildings, but the Federal Government prohibits smoking in federally owned facilities except in designated smoking areas. AMA has drafted federal legislation requiring hospitals wanting to participate in Medicare and Medicaid to be smoke-free and has distributed copies of the proposed legislation to members of Congress.

The Steering Committee forwarded a copy of Resolution A to the Kentucky Hospital Association as KMA's policy regarding smoking in hospitals with the request that KHA consider this recommendation.

Resolution N — Hospital Security. This Resolution called for KMA to urge the Kentucky Hospital Association to call on "all Kentucky hospitals to institute and/or maintain increased security measures, such as general identification, patrols, visual monitoring systems, and other systems as necessary in order to protect staff, patients, employees, residents, and students, both in-house and on surrounding grounds and parking areas." KHA has no formal policy on this matter, but has encouraged each hospital to have its own security system. A letter was forwarded to KHA requesting Resolution N be implemented by KHA. The Hospital Association has asked KMA to advise them if any specific problems come to our attention.

Resolution R — Inappropriate Requirements for Hospital Membership, as reviewed by the 1987 House of Delegates, called on each physician to "maintain what he or she determines to be a reasonable amount of liability insurance," specified that "a physician need not divulge whether such coverage exists," and that "each physician should reject efforts by insurance companies to set requirements for medical staff membership." The House felt the issues discussed in Resolution R should be looked at more closely and referred Resolution R for further study, requesting that this be considered by the Board of Trustees at its December 1987 meeting. The HMSS was asked to review Resolution R and make recommendations. The Steering Committee discussed this matter at great length at its November 1987 meeting and presented to the Board a Substitute for Resolution R. The Board, at its December meeting, rejected the Steering Committee's Substitute and referred this matter back to the HMSS for further clarification.

At its March 1988 meeting, the Steering Committee once again discussed the issues covered by Resolution R. Invited to that meeting was a representative of the Daviess County Medical Society, which had introduced the original Resolution because of the increased demands by insurance carriers that hospitals enforce increasing limits of liability insurance coverage for staff membership. A KMA Trustee with knowledge of problems similar to those of the Daviess County Medical Society also assisted. In addition, KMA's legal counsel was asked to provide input into this matter because of possible legal ramifications. Following an in-depth discussion of all information and materials, a revised Substitute

for Resolution R was written and forwarded to the Board of Trustees.

At its April 1988 meeting, the Board approved the revised Substitute for Resolution R, and it is being presented by the Board to this year's House of Delegates as Resolution A (1988). Much thought and work have gone into the development of the 1988 Resolution A, and the HMSS encourages the House of Delegates to adopt this Resolution.

It has been my privilege to serve as Chairman of the KMA Hospital Medical Staff Section since its inception four years ago. I would like to express my appreciation to the medical staffs of those hospitals which have chosen to be active in the KMA-HMSS. I encourage those other medical staffs to elect their representatives as soon as possible and participate actively in the Section, as it is an effective mechanism for dealing with mutual problems of hospital medical staffs and discussing matters involving medical staffs and hospitals. I would also encourage participation in the AMA-HMSS activities.

I extend my sincere gratitude for the dedication of the 1987-88 Steering Committee members in dealing with issues referred to the HMSS. Those members are James Russell, MD, Lexington; Roderick MacGregor, MD, Bedford; Alfred Thompson, Jr, MD, Louisville; Harold Bushey, MD, Barbourville; John Logan, III, MD, Henderson; and John Jones, MD, Flatwoods.

The establishment of the KMA-HMSS and its continued development into a vital resource for the practicing physicians of Kentucky is due in great part to the sustained efforts of Doris A. Crume and other KMA staff members. Without her assistance and constant encouragement, the work of the KMA-HMSS would not be completed. There are no words or gestures that can adequately express my appreciation.

I will continue to represent my hospital within the Hospital Medical Staff Section, but I encourage you to work with and support the efforts of the new Chairman, Don Swikert, MD, and the other members of the 1988-89 Steering Committee. I conclude by urging the Association's continued support of the Hospital Medical Staff Section.

William B. Monnig, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Emergency Medical Care Seminar Planning Committee

The Emergency Medical Care Seminar Planning Committee conducted the 18th Annual KMA Emergency Medical Care Seminar on June 7, 8, and 9 in Louisville. The two and one-half day program featured "Pediatric Emergencies," "Neurologic Emergencies," and additional topics on "HIV Infection-Hepatitis B-Risk to Health Care Workers" and "Law for EMTs/Paramedics."

Approximately 400 participants attended the seminar this year, which is accredited by the Kentucky Nurses Association; EMTs; paramedics; the Kentucky Chapter, American College of Emergency Physicians; and the Kentucky Chapter, American Academy of Family Physicians.

More than 50 physicians, nurses, EMTs, and paramedics serve as faculty members on the program. Practically all speakers serve without an honorarium which allows the Planning Committee to maintain a relatively low registration fee of $25 per day which includes breakfast, lunch, and dessert break in the afternoon.

The Committee is appreciative of those who participate on the program and provide emergency personnel with the most up-to-date information. The meeting is well received and is recognized as one of the outstanding programs on emergency medicine. Program content is presented on a high level which attracts the most active persons in the emergency field. The Committee will be reviewing critiques of the meeting and will add other programs as the need arises.

The Chairman takes this opportunity to applaud the efforts of the members of the Planning Committee who contributed to the seminar's success. The members of the Committee are: James L. Combs, MD; Diller B. Groff, MD; Charles B. Spalding, MD; Donald M. Thomas, MD; Barbara Cox, RN; Tommy Thompson, EMS Training Coordinator; and Cheryl Westbay, RN.

On behalf of the Committee, we are sincerely grateful to the KMA House of Delegates and the KMA Board of Trustees for their continuing support of the program.

E. Truman Mays, MD
Chairman

RECOMMENDATIONS:

1. The Emergency Medical Care Seminar Planning Committee recommends that the Emergency Medical Care Seminar be continued in 1989.

Recommendations, Reference Committee No. 2:

Reference Committee No. 2 reviewed Report No. 18, Report of the Emergency Medical Care Seminar Planning Committee, with its Recommendations, and recommends that it be adopted.

Report of the Physician Manpower Committee

The Physician Manpower Committee was established by the KMA Board of Trustees to work with Kentucky's medical schools in an effort to determine the state's current and future physician manpower needs.

This year, the Committee considered Kentucky's physician manpower situation using data available from a study

conducted by the Graduate Medical Education National Advisory Council (GMENAC). According to the GMENAC formula, Kentucky's recent rate of growth relative to the nation is higher, but the ratio between physicians and population remains below the national average. Nationally, some medical communities have been greatly affected by the influx of foreign medical graduates, but this has not had a great impact in Kentucky since licensing requirements were changed. Kentucky's medical schools have also been very restrictive in making clerkships available to graduates of off-shore schools.

Is is apparent that many factors come into play when trying to assess physician manpower needs. The Committee has found that one of the difficulties in using the GMENAC approach is the long pipeline of seven to ten years which exists before a medical student class has any impact on the medical practice community. Larry Fowler, representing the Council on Higher Education, indicated that from 1976 to 1986, Kentucky had an annual net gain of about 200 physicians per year. However, in 1987 this number dropped to 127.

While there was a gain overall in the state, the gain in rural counties is at a lower rate than Jefferson and Fayette Counties. Rather than having an excess of physicians, the more immediate problem in Kentucky comes from physician maldistribution, not only in the rural areas, but in urban areas such as west Louisville and north Lexington which are underserved, according to information from federally subsidized primary care centers in these areas.

Don Coffey, with the Department for Health Services, provided the Committee with information on physicians and population by county indicating the 20 most critically underserved counties. Counties are ranked by physician-to-population ratio, with a normal ratio falling between 1/1500 and 1/2500, and a ratio of 1/3500 or more designating a critical area. A major concern of the Committee is finding incentives to attract physicians to underserved areas.

Along these lines, it was suggested by Mr. Coffey that a joint survey be conducted by the Committee and the Department for Health Services of young physicians who became licensed and began practice in Kentucky during the past few years. The focus of the survey would be on identifying the considerations that most influenced their decision on where to locate their practice. Similar studies have been done in other states, and the results indicate that the two greatest influences on practice location are the location of residency training, first, and medical school location second.

Bob Hurst, with the Kentucky Department for Health Services, told the Committee that his department is involved in recruiting primary care physicians to the 20 most critical areas of Kentucky, as well as contacting medical students with information on practice opportunities.

It was pointed out that the National Health Service Corps, which at one time was active in physician recruitment, is practically extinct, and that the Rural Kentucky Medical Scholarship Fund is the only program actively placing physicians in underserved areas. The Rural Kentucky Medical Scholarship Fund has also instituted a pilot program this year that offers $6,000 per year toward a physician's educational debt if he practices in a critical area.

This year the Committee was assigned Resolution M, which was introduced by the Resident Physicians Section and referred to the Physician Manpower Committee by the Board of Trustees. Resolution M asked the KMA to study the issue of hours on-call by resident physicians in Kentucky and its impact on quality of patient care and resident physician education. During the Committee discussion of Resolution M, Alfred Thompson, MD, Associate Dean of the University of Louisville School of Medicine, stated that the Accreditation Council for Graduate Medical Education (ACGME) has established guidelines for hours and scheduling. These guidelines will be considered by the Residency Review Committee and will be incorporated into its requirements over the next two years. The Physician Manpower Committee agreed that this issue would be most appropriately addressed by the physician educators rather than the Licensure Board or the Legislature.

Information concerning resident working hours is available from other states and will be distributed to the Committee for future consideration. In New York, for example, the 13,000 residents there will be working under rules adopted by the State Hospital Review and Planning Council and duties will be restricted to no more than 80 hours per week. They will not be required to work more than a 24-hour shift and cannot be assigned to emergency room duty for more than 12 consecutive hours.

Along these lines, a report from the AMA Council on Medical Education was reviewed which has established ten guiding principles on issues of resident working hours and supervision. The Council asked the AMA House of Delegates to

- recognize that problems exist with regard to resident supervision, which may compromise the educational program, the health of residents, and patient care;
- urge the ACGME to revise the Essentials of Accredited Residencies in GME to emphasize the importance of resident supervision, work hours, and stress;
- urge each Residency Review Committee to revise its Special Requirements to define the supervision and the maximum work hours to avoid excessive stress and fatigue, to assure quality patient care, and to attain the objectives of the educational program.

The Physician Manpower Committee feels it is appropriate to continue to pursue this matter at the local level to ascertain Kentucky-specific data. As Chairman, I would like to thank the members of the Committee for their interest. The Committee will continue to review and study data to provide further direction as to the needs of physician manpower in Kentucky.

Robert R. Goodin, MD
Chairman

RECOMMENDATIONS:

1. The Physician Manpower Committee recommends that the issue of resident physician hours continue to be studied to determine and clarify the effects of working conditions on quality care.

Recommendations, Reference Committee No. 2:

Reference Committee No. 2 reviewed Report No. 19, Report of the Physician Manpower Committee, with its Recommendation, and recommends that it be adopted.

Resolution A

Inappropriate Requirements for Hospital Staff Membership Board of Trustees

WHEREAS, liability insurors of hospitals continue to demand that hospitals enforce increasing limits of malpractice insurance for staff membership, and

WHEREAS, there has been no reasonable restraint on this indirect tax on the public, and

WHEREAS, the primary function of hospitals and physicians should be to help people maintain life and health and not to compensate for liability or for inevitable bad results, and

WHEREAS, the competence of a physician is established by factors other than insurance coverage, and

WHEREAS, it is not appropriate for an insurance company to dictate the requirements for membership on a medical staff, now therefore be it

RESOLVED, that each physician should maintain what he or she determines to be a reasonable amount of liability insurance, and be it further

RESOLVED, that physicians should not be required to divulge the amount of their professional liability coverage but should simply verify that the minimum level of coverage required by the medical staff's constitution and bylaws is in effect, and be it further

RESOLVED, that physicians should act through their medical staffs in taking all lawful measures to prevent insurance companies from dictating criteria for medical staff membership. Those criteria should focus on the capabilities and qualifications of the members to meet the health needs of their patients, and not upon mechanisms by which the hospitals' cost of doing business can be shifted to members of its medical staff, and be it further

RESOLVED, that the Resolution be introduced in December 1988 to the AMA House of Delegates through KMA Delegates to the AMA and to the AMA Hospital Medical Staff Section through the Chairman of the KMA-HMSS.

NOTE: Resolution R (Ann. Mtg.-87) was referred to the Board of Trustees by the 1987 House of Delegates. It has since been revised and is submitted to the 1988 House of Delegates in its present form as Resolution A.

Recommendations, Reference Committee No. 2:

The Reference Committee reviewed Resolution A, Inappropriate Requirements for Hospital Medical Staff Membership, introduced by the Board of Trustees. There was a great deal of discussion in regard to Resolution A. The consensus was that the Resolution probably best represented the interest of physicians. Reference Committee No. 2 recommends that Resolution A be adopted.

Reference Committee No. 2 recommends the adoption of the Report of Reference Committee No. 2 as a whole.

Mr. Speaker, I would like to thank the other members of the Committee: William L. Miller, MD, Greenville; Charles H. Veurink, MD, Richmond; Joseph G. Weigel, MD, Somerset; and C. Milton Young, III, MD, Louisville, for their time spent in listening to testimony and for their opinions and assistance in preparation of this Committee report. I would also like to thank our secretary, Beth Thomas.

REFERENCE COMMITTEE NO. 2

Russell H. Davis, MD, Pikeville, Chairman
William L. Miller, MD, Greenville
Charles H. Veurink, MD, Richmond
Joseph G. Weigel, MD, Somerset
C. Milton Young, III, MD, Louisville

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 3

Paul R. Smith, MD, London, Chairman

Reference Committee No. 3 considered the following Reports and Resolutions:

22. Report of the Maternal Mortality Study Committee
23. Report of the Committee on National Legislative Activities
24. Report of the Committee on State Legislative Activities
25. Report of the Committee on Impaired Physicians
26. Report of the Committee on Care for the Elderly
5. Report of the Chairman, Board of Trustees, Recommendation #2 (page 5.15) and Report of the Ad Hoc Committee on Professional Liability Insurance, *only*

Resolution K — Enforcement of DUI Laws (Resident Physicians Section)

Resolution L — Availability of Obstetrical Services (J. Gregory Cooper, MD, Cynthiana)
Resolution N — Warnings Against Use of Alcohol During Pregnancy (Fayette County Medical Society)
Resolution P — Physician Certification of Cause of Natural Death (Bell County Medical Society)
Resolution T — Compulsory Chiropractic Health Insurance Coverage (Daviess County Medical Society)
Resolution U — Professional Liability Insurance Task Force (Board of Trustees)
Resolution X — KMA Committee on State Legislative Activities (Board of Trustees)
Resolution Z — Referral of Preoperative and Postoperative Cataract Surgical Patients (Board of Trustees)
Resolution DD — Carrier Influence on Medical Practice (KY Society of KOGS — KY Section of ACOG)
Resolution EE — Noninsurance Assets (KY Society of KOGS — KY Section of ACOG)
Resolution FF — Not-for-Profit Hospital Pricing (KY Society of KOGS — KY Section of ACOG)
Resolution GG — Neurologically Impaired Newborns (KY Society of KOGS — KY Section of ACOG)

ITEMS FOR CONSENT

Reference Committee No. 3 reviewed the following items and recommends they be filed, by consent of the House, without discussion:

22. Report of the Maternal Mortality Study Committee — filed
23. Report of the Committee on National Legislative Activities — filed
25. Report of the Committee on Impaired Physicians — filed

Reference Committee No. 3 would like to express appreciation to the Chairmen and members of the committees, whose reports have been filed, for the time and effort spent in gathering this information for the House of Delegates.

Mr. Speaker, Reference Committee No. 3 recommends adoption of the Consent Calendar as a whole.

Report of the Maternal Mortality Study Committee

The Maternal Mortality Study Committee met once during the Associational year. The date of the meeting was September 15, 1987. Nine cases were considered by the Committee, three of which were indirect obstetric deaths, six were direct obstetric deaths with possible preventable factors. It should be stated that an indirect obstetric death is one that would occur whether the patient was pregnant or not. Direct obstetric death is one with factors in the pregnancy causing maternal demise. This does not necessarily impute fault on the part of the people or institution caring for the patient. The Committee met only once this year because of the few cases to be considered. We hope this record continues.

It is a great pleasure to work with and chair the Maternal Mortality Study Committee. The very diligent work of Doctor John Petry should again be acknowledged for he spends many hours compiling the material and analyzing it for presentation to the members of the Committee.

1986 MATERNAL DEATHS

Age	Race	Para		Autopsy
26	W	gr 5	Peritoneal sepsis infection, liver, spleen, small intestine. Referred back to UK. Operated on post section for gallbladder at another hospital. **Direct obstetric death.**	Yes
21	W	gr 1	Admitted with preeclampsia, bed aspiration emergency section. **Direct obstetric death.**	No
38	B	gr 3	Delivered at home, exsanguinated, found by daughter, retained placenta. **Direct obstetric death.**	
16	W	gr 1	Delivery by Caesarean, congestive heart failure; cardiac arrhythmia. **Direct obstetric death.**	Yes
36	B	gr 2	Ectopic pregnancy, hemorrhagic shock. **Direct obstetric death.**	Yes
23	W	gr 1	Respiratory failure from RDS with associated Raynauds disease. **Direct obstetric death.**	Yes
23	W	gr 1	Marfan syndrome, ruptured aortic aneurysm; postmortem Caesarean, infant stillborn. **Indirect obstetric death.**	No
21	B	gr 1	Diagnosed coagulopathy 1985; delivered Caesarean, fetal distress. Death multiple hemorrhagic areas of brain. **Indirect obstetric death.**	Yes
23	W	gr 2	Head-on auto accident. **Nonobstetric death.**	No

27	B	gr 2	Struck on sidewalk by car; DOA. **Nonobstetric death.**	No
	Korean		Obtaining information.	

John W. Greene, Jr, MD
Chairman

Report of the Committee on National Legislative Activities

The Committee on National Legislative Activities has been extremely busy this year, as have legislative departments at all levels of the Federation. Medically related legislation continues to occupy a prominent position in the Congressional view. Ironically, while the entire Congress has recently approved an expansion of the Medicare Program in terms of dollars, the Program is subject to ever-increasing financing reductions; nor has the Medicare Program been unique in receiving Congressional scrutiny relating to finances. The medical profession and those responsible for medical care financing were forced to confront a number of major issues. Only highlights will be discussed here.

A major occurrence this year was the passage of a catastrophic Medicare provision. In this context, KMA's primary activity was in contacts with Congressmen in opposition to drug provisions of the law. The bill would have allowed the Secretary for Health and Human Services the authority to develop standards for prescribing, dispensing, and use of pharmaceuticals for Medicare patients. Through efforts at all levels of the Federation, this provision was mitigated somewhat. While the Secretary still potentially has the authority to create a Medicare Formulary, it will be subject to medical input.

In the summer, the President signed the Medicare Catastrophic Protection Act. The major provisions of the bill are that after a patient has paid an annual $580 hospital deductible, all further care is "paid for." No patient will be required to spend more than $1,400 out-of-pocket for Part B, or physician, charges (Medicare allowable charges). There is a $600 deductible for drugs. Any amount spent out-of-pocket above this figure will be reimbursed to the patient at a 50 percent rate. The entire proposal will be funded through additional patient premiums. Initially, an extra $4 premium per month will be charged, up to a maximum of $10.20 by 1993. All premiums will be based on the Medicare recipient's income.

Of related interest this year was the introduction of H.R. 4455, which would completely reform the Medicare Program. This bill was generated directly by the Report of the Board of Trustees MM of the American Medical Association. This bill would provide Medicare Program coverage through a voucher system marketed by private insurance with specified benefits. There would be a limit of $2,500 on out-of-pocket expenses for an individual, or $3,750 for a family. The Program would be funded through payroll deductions sufficient for the funding of those currently working, and the Medicare Trust Fund would finance costs for those persons already eligible for Medicare.

Changes to the Medicare Program caused by the Omnibus Budget Reconciliation Act of 1986 (OBRA 86) were the subject of intense activity by the Federation. Through numerous contacts at all levels, and through prolonged communication between the AMA and the Health Care Financing Administration (HCFA), several of the more onerous provisions of OBRA 86 were addressed. These related primarily to the so-called "medically unnecessary" provision. The AMA was successful in persuading HCFA to require that carriers advise physicians before claims are denied and before refund letters are sent. Until these changes occur, the AMA had requested that a moratorium be placed on issuance of refund letters, which HCFA declined to do.

The AMA also attempted to persuade HCFA to revise refund notice requests to physicians to make such letters less offensive and accusatory, and also to assure that cases where refund letters were generated would be reviewed by physicians before they were authorized to be issued. In addition, the AMA attempted to develop a standardized letter to advise patients that services to be provided might not be paid for by Medicare. HCFA would not allow the use of a generic letter, but work continues by the AMA and HCFA on developing some general guidelines for such a letter. The AMA was successful in getting HCFA to educate carriers on "medically unnecessary" services versus "noncovered services," and thereby precluded negative denial letters. Discussions are ongoing concerning efforts to advise physicians and carriers beforehand as to what services will be considered medically unnecessary.

On a related issue, work continued this year, under contract by the Harvard Medical School, to develop a Relative Value Scale (RVS). This RVS was called for in a previous year's Budget Reconciliation Act and has been the subject of some controversy. The RVS will be resource-based rather than difficulty-based. In determining relative values, the scale will take into account the time a physician has spent in training, his educational debts, overhead operation costs, and so forth.

The developmental timetable called for submission of the RVS to the Department of Health and Human Services by July 14, 1988, but recently it has been learned that the study will not be submitted until late August. The study will then be given to the Physician Payment Review Commission (PPRC), a group also mandated by OBRA 86, in late September, and the PPRC will hold a hearing in early November. The report will finally be submitted to Congress probably in March 1989, and could be implemented in January 1990.

While it is likely that if the RVS is developed, reimbursement will change across specialties, it is unlikely that overall reimbursement to physicians will change.

Another issue that saw intense effort on behalf of the Federation was implementation of a provision of the Health Care Quality and Assurance Act of 1986. This act would create a national clearinghouse and data bank on physicians and physician activities and would provide good faith peer review immunity. The recent critical issue has been data reportable to a national data bank, and the Federation was quite active in attempting to influence reportable items.

On behalf of the Federation, the AMA is working to: change reporting requirements on malpractice payments if the physician wins on appeal; develop a coding system for reporting acts or omissions because the current requirements for narrative reporting would be too subjective; change the requirement for reporting adverse actions on clinical privileges in those instances where privileges were reinstated; require reporting of peer review investigation activities only if adverse action is taken; and mandate that information from the data bank can be obtained by nonauthorized agents (attorneys) only with a court order. Because of the reporting requirements of Kentucky's Medical Practice Act, it is felt that the law will have little effect in the state.

Efforts directed at clinical laboratories also demanded considerable contact and activity by the Federation. As of this writing, the House Energy and Commerce Committee is considering national standards for clinical laboratories to assure that fraud and "kickbacks" do not take place. Similarly, the Senate Labor and Human Resources Committee and the Senate Government Affairs Subcommittee are considering legislation aimed at preventing fraud and abuse and assuring quality. Finally, Representative Ron Wyden (D-OR) has introduced H.R. 4325, which is aimed at quality control of physician office laboratories.

It is postulated that all of these efforts come in the wake of national news stories published this year, which allegedly showed wide discrepancies in clinical laboratory test results. While the Federation certainly cannot be in opposition to quality assurance, there is serious concern that sweeping legislation may be enacted before the scope of the problem is truly ascertained. Moreover, there is very intense concern about the question of quality in physician office laboratories. It is KMA's contention that most laboratory tests performed in physicians' offices are so elementary that quality control is not an issue, or where more sophisticated tests are performed, appropriate personnel are in place to oversee quality. This issue will continue to receive wide publicity, both at the state and national levels, for the next few years.

Another concern this year has been efforts by the Ways and Means Oversight Subcommittee to expand the definition of unrelated business income for tax purposes as it applies to nonprofit organizations. This would have a direct effect on medical societies and medical associations. KMA enacted a number of contacts on this issue supporting taxation of income derived from true business activities. However, equal opposition has been expressed to taxation of income derived in support of the nonprofit status of the organization. In other words, the possibility has existed that the proposed tax provision would apply to dues income. While Kentucky did not have any Congressional members on the Oversight Subcommittee, numerous contacts were initiated, and through the efforts of our Congressmen, it was learned that, at least as this is written, the unrelated business income tax would not apply to dues income. Efforts on this issue continue.

This report has provided only highlights of the major issues that were addressed this year; numerous lesser matters received attention. Overall, it is gratifying to report that relationships with Kentucky's Congressional Delegation remain most cordial, and the membership should be grateful for the general support and assistance provided by our Congressmen.

As Chairman, I would like to thank everyone who has had involvement in the legislative process this year, and most particularly, the Key Contacts and KMA Officers.

Fred C. Rainey, MD
Chairman

Report of the Committee on Impaired Physicians

This has been a very active year for the Committee on Impaired Physicians. The Committee met every two months, and a Subcommittee has met several times outside of the scheduled gatherings. The IPC Subcommittee was established to meet with physicians between meetings of the regular Committee, to help guide the Committee's current and future efforts, and to refine the aftercare program.

In addition to its regular work, the Committee has achieved some overall program goals which are gratifying. Working with the University of Louisville Department of Family Practice, efforts have been made to develop a program to provide training to recovering physicians for reentry into the mainstream of the practicing medical community.

In addition, steps have been taken to establish a chemical dependency program in the Department. The Committee assisted in these efforts by sponsoring training for a designated staff member in a residency program on addiction that was conducted in Georgia. The result has been that the Department now has a ten-week elective on addiction treatment, and members of the Committee are helping in the development of a curriculum.

The Committee is also gratified to announce that information on substance abuse will be imparted to junior students at the University of Kentucky as part of the introduction to their clinical years. Substance abuse will also be covered during their Internal Medicine rotation, using patients on their service to demonstrate the clinical aspects of this disease.

Continuing study is being given to the creation of a posi-

tion of full-time, salaried medical director for impaired physician activities. Up to this point, there has not been sufficient activity to warrant such a position, but it is felt that such an activity level will soon be reached. The operation and administration of such an office can be fairly easily developed, but the obvious problem is funding. Further study will be given to this issue.

During the year, the Committee made contacts with other health professional groups to assist in formalizing their programs for dealing with impaired members. Other external activities included attendance by Committee members at the Annual AMA Conference on Impaired Professionals, which is becoming a significant and helpful meeting, and the provision of speakers to other meetings around the state, which included the Auxiliary's Annual Meeting and a meeting of the KMA Hospital Medical Staff Section.

Liaison with the Board of Medical Licensure was strengthened this year. A distinct meeting was held with Licensure representatives and investigators to discuss streamlined efforts of communication and assistance to physicians with impairments. It is gratifying to report that the Licensure Board routinely relies on the Committee to assist such individuals, and referrals to the Committee are frequent.

Much work was devoted to improving the Committee's aftercare program, which included more aggressive followup, increasing the number of urine screen tests conducted, and working to put more responsibility for the aftercare on the individual being treated.

Solicitation will again be made this year for the KMA Benevolent Fund, which has proven most helpful. The Fund has been utilized on three occasions this year. In one instance, the Fund was used to help defray treatment expenses for an impaired individual, and in two other situations, urgent transportation costs were met by the Fund in relation to acute treatment. In each of these situations the Fund was used as a loan, and appropriate steps are being made to see that funds which have been expended are returned.

Thought is being given to completion of statistics on the Committee's efforts for educational and research purposes. The Committee has no intent to "keep score," nor to aggrandize its efforts. Over a long period, however, such research might prove helpful in preemptive efforts.

"Thanks" is an inadequate word to offer to the Committee members and other individuals who have helped in the Committee's efforts, but appreciation is owed by the entire profession. Even though the members and others have provided this assistance for their own motivating reasons, it has been an effort of "tough love."

David L. Stewart, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Committee on State Legislative Activities

The 1988 session of the Kentucky General Assembly was a high point in KMA's legislative history. We closely monitored and worked with over 50 pieces of legislation that directly affected the practice of medicine. The PLI campaign was extremely successful, and far-reaching legislation, including regulatory reform in the insurance industry, should have a lasting impact, not only in the area of malpractice, but in other phases of the insurance industry as well. House Bill 551, House Bill 552, and HCR 62 comprised the bulk of the liability reform measures, and I refer you to the Report of the Ad Hoc Committee on Professional Liability Insurance for that information.

The KMA House of Delegates, over a period of several years, has also directed the Committee on State Legislative Activities to pursue several other legislative goals. In 1986, the KMA House of Delegates went on record in support of mandatory sex education. House Bill 345, adopted by the 1988 Kentucky General Assembly, mandates that sex education be taught to students in kindergarten through 12th grade.

Secondly, the House directed that KMA provide strong support for child seat restraint legislation with penalties for those who refuse to comply with the provision. We are pleased to report that the 1988 Kentucky General Assembly enacted the penalty provisions.

A third directive instructed the State Legislative Committee to support restrictions on all-terrain vehicles. Senate Bill 309 was a compromise among industry, the Kentucky Transportation Department, and the Kentucky Medical Association. However, after moving through the Senate rather quickly, the bill stalled in the House Transportation Committee. We plan to reintroduce the legislation in 1990.

The final directive involved support for the living will concept. We did support that measure; however, numerous forces combined to defeat it in the House Health and Welfare Committee where it fell two votes short of passage.

Indigent Care, which from KMA's standpoint is a priority issue, was placed on the back burner in 1988 as a result of severe budgetary shortfalls. Legislation which would have been extremely favorable to medicine was introduced by Senator Benny Bailey of Hindman. However, mandatory provisions for employers and provisions unacceptable to hospitals created a roadblock for even a decent hearing on this bill.

Legislation on AIDS did not create quite as many problems for us as we had anticipated. Members of the General Assembly seemed to be well educated on the matter, and leadership resisted numerous punitive measures that were unnecessary and would not have been in the best interest of patients. House Bill 50 was the major effort in the General Assembly in the area of AIDS. We worked with the sponsor during the General Assembly and were able to resolve most problems, but concern still exists with autologous transfusions. We are working with the Cabinet for Human Resources, Kentucky

Hospital Association, the sponsor, and others in drafting appropriate regulations.

As you can see, KMA had a very positive legislative program during the Kentucky General Assembly, contrary to our usual "hold that line" posture. Nonetheless, I must report to you that we continue to spend a tremendous amount of time and effort in defeating unneeded, unnecessary, ill-conceived legislation.

While we reported to you weekly throughout the Session, it is important to outline some of the ridiculous measures introduced. The Association opposed the following bills, which were defeated by the General Assembly: increase the statute of limitations on malpractice from one year to two years; require physicians' malpractice insurance premiums to be based on individual experience; require AIDS testing prior to marriage; repeal the mandatory motorcycle helmet law; require physicians to collect a portion of the Medicaid fee from patients; require an optometrist on all local and regional health boards; limit expert witness fees; remove requirement that hearing impaired receive physician exams before purchasing hearing aids; require extensive investigation of all health personnel prior to hiring (Donald Harvey bill); require diagnosis to be affixed to prescriptions and containers; halt or severely restrict use of animals in medical experiments; require physicians to report Medicaid patients who request itemized statements; permit open access of Medicaid patients' medical records by Medicaid officials; require triplicate copies of prescriptions; require every physician's laboratory to be licensed; permit nurses to prescribe, dispense, and diagnose; place physicians who dispense under the Pharmacy Act. These are just a few of the ill-conceived legislative proposals with which KMA had to actively deal.

There were many other legislative proposals which we were forced to amend. While not as harsh as the above, they would have had a detrimental effect on the practice of medicine. This Report does not even take into account numerous proposals considered but never introduced due to KMA's presence or known opposition.

The Committee on State Legislative Activities met on five occasions during the Associational year, working with the Quick Action Committee, Officers, and Trustees on the legislative campaign. In addition, the State Legislative Committee Chairman and Quick Action Committee, composed of KMA's President, President-Elect, Secretary-Treasurer, Chairman of the Board, and this year the Immediate Past President, met weekly during the Session. This amounted to 15 separate meetings for this particular group. The KMA Ad Hoc Committee on Professional Liability Insurance also met in Frankfort during the Session to review liability proposals. As you can see, physicians involved in the legislative effort spent a great deal of time on your behalf.

To augment the legislative effort, we conducted a Legislative Seminar in Frankfort in January 1988. General Assembly leadership headlined an outstanding program, with approximately 100 physicians and spouses attending.

We also developed a "Legislative Handbook," printed and disseminated to members through the January issue of the KMA *Journal*. The Handbook was designed to provide legislative background and personal information for members to work with their legislators during the Session.

The "Legislative Committee Bulletin" was mailed weekly to every KMA member outlining the week's activities and seeking support through telephone calls and letters. As a result, we had the finest participation and support we have ever experienced from members of KMA.

We need to recognize a few groups who went beyond the call of duty to make our legislative campaign successful. In early December, the Daviess County Medical Society held a breakfast meeting on a Saturday morning and invited every legislator in the district. The key to our success in the liability campaign hinged on Speaker of the House Donald Blandford of Philpot. Over 65 Owensboro physicians showed up at the 7:00 AM breakfast and successfully obtained the support of the Speaker for our campaign. The Speaker was the primary sponsor of the Liability Task Force recommendations.

Secondly, Christian County physicians conducted a Saturday morning meeting, which 30 doctors attended. A key to our campaign was the support of House Banking and Insurance Committee Chairman James Bruce; Senate Banking and Insurance Committee Chairman Pat McCuiston; and House State Government Committee Chairman Ramsey Morris. All three Christian County legislators were in a position to block liability reform. As a result of the local physician effort, the way was cleared for passage of the liability program.

In northern Kentucky, Boone, Campbell, and Kenton County Societies conducted a prelegislative meeting with over 150 physicians and spouses attending, including 12 Senators and Representatives. Every northern Kentucky legislator, with one exception, supported and worked for the package.

The Jefferson County Medical Society conducted weekly visits to Frankfort, and every KMA Key Contact from Jefferson County made the trip to Frankfort and personally discussed the liability issue with their legislators. Consequently, every Jefferson County legislator supported the package.

The Fayette County Medical Society conducted legislative meetings before and during the General Assembly to augment the KMA effort and assist in the campaign. Major Fayette County players, who were keys to our liability efforts, included prime sponsors Representative Bill Lear, Senator Ed Ford, and Senator Jack Trevey, MD.

We realize there were many other group efforts made, of which we are unaware. However, we want to thank every physician, county medical society, and hospital medical staff who worked with us during this campaign. If you made some special effort or developed a local program, please let us know. We are going to need the same intensive legislative effort in 1990.

A major contributing factor to our legislative success

belongs to KEMPAC. KEMPAC contributed over $80,000 to candidates for the Kentucky General Assembly and, as a result, made our job much easier. Experience shows that few physicians privately contribute to state legislative candidates. Without KEMPAC support, the PLI campaign may have faltered, and numerous negative legislative proposals could have been adopted. One hundred dollars per year is a small price for the maintenance of a free and independent practice of medicine.

Special thanks go to the Auxiliary of KMA for the interest of its members and the numerous activities they undertook to assist in the liability program. President Pam Potter gave many hours to the campaign and worked with us in rallying AKMA support. Special thanks also go to Mrs. Thomas Slabaugh, Mrs. Russell Travis, and Mrs. John Cronin, who assisted us by providing phone banks and direct contacts with legislators.

Our Key Contact System functioned well this year, and we owe our gratitude to those Key Contacts who maintain year-round rapport with their legislators.

Two gentlemen who deserve much credit for our legislative success are Senator John Trevey, MD, and Senator Nicholas Kafoglis, MD. Both physicians hold seats on the Senate Health and Welfare Committee and are highly respected, not only within their party, but by other legislators as well. A large measure of our success can be credited to their efforts, and we wish to publicly thank them for their assistance.

Our lobbying team in Frankfort deserves mentioning. Senator Nick Kafoglis noted in a letter to me, "Don Chasteen, Bill Doll, John Cooper, and Donna Young did a magnificent job and deserve a great deal of praise. I am not aware of a more effective team in Frankfort." Their efforts were augmented by the KMA staff who worked many long hours supporting the legislative campaign.

Several recurring legislative proposals come up every Session. We continue to be alarmed with nonphysicians legislating their way into the practice of medicine. Your Committee on State Legislative Activities and Quick Action Committee wrestle with this dilemma every Session. We would like to find a uniform method of relating to allied health care personnel and responding to their legislative proposals. Most legislators generally oppose these inroads, which usually end up increasing the cost of health care. Unfortunately, I'm not optimistic that a way can be found. Proposals in 1988 ranged all the way from simple certification to permission to prescribe pharmaceuticals. A study completed by the Committee shows that at present there are twenty-six nonphysician practitioners certified or licensed under the Occupations and Professions Division, five under the Kentucky Board of Medical Licensure, and seven independently licensed.

Secondly, we need to sharply define KMA's position on funding indigent care. Business, industry, and health insurors simply refuse to accept a tax proposal relating to indigent care unless it is broad based. Without the support of these groups, we are not optimistic that this growing crisis can be resolved. Its solution, if there is one, will probably be handled on the Congressional level.

Thirdly, we see a growing trend whereby legislators seek to statutorily define medicine and how, where, and when it is practiced. All of us have been concerned with the desire of government review organizations to adopt cookbook medicine. Unfortunately, members of the General Assembly have the same inclination. The 1984 General Assembly required that a breast cancer pamphlet be provided to every breast cancer patient. In 1988 members of the General Assembly sought to statutorily require that physicians counsel all patients exposed to the HIV virus. We intend to continue opposing statutorily required patient treatments as we find them unacceptable in the physician-patient relationship. Due to continuing scientific breakthroughs, it is highly inappropriate to chisel the practice of medicine in stone.

To my knowledge, Kentucky is one of the few states where mandatory participation in Medicaid and Medicare has not become an issue. We credit the Kentucky Physicians Care Program for that success and the 2,200 physicians who give of their time and effort to keep the program alive. However, we remain alert to the possibility that the bill may be introduced in 1990.

At the final meeting of the Committee on State Legislative Activities, a recommendation was made that a statewide Head Injury Registry be established, and that physicians throughout the Commonwealth participate in and contribute to the voluntary registry program.

We completed an outstanding Session, and many people contributed to its success, including county medical society members and staffs, KMA Key Contacts, Officers and Trustees, members of the Committee on State Legislative Activities, members of the Ad Hoc Committee on PLI, and KMA staff. It was a team effort and one of which we can be proud. However, major success for this legislative campaign can be attributed to you, the individual physician. For the first time in the history of KMA, Kentucky physicians got involved and achieved a success that few thought possible. Through your efforts, members of the General Assembly supported KMA's position, and, as a result, we are all winners.

Wally O. Montgomery, MD
Chairman

RECOMMENDATIONS:

1. The Committee on State Legislative Activities recommends that a statewide Head Injury Registry be established, and that physicians throughout the Commonwealth participate in and contribute to the voluntary registry program.

Recommendations, Reference Committee No. 3:

Reference Committee No. 3 reviewed the Report of the

Committee on State Legislative Activities and its Recommendation for the establishment of a statewide Head Injury Registry and for physicians throughout the Commonwealth to participate in and contribute to the voluntary registry program.

Reference Committee No. 3 recommends this report and its Recommendation be adopted.

Report of the Committee on Care for the Elderly

This year, the Committee on Care for the Elderly continued its efforts in geriatric education and in the area of elderly abuse. In addition, some new directions were established that will be pursued in the coming year.

A series of articles was published again this year in the KMA *Journal* under the heading of "Clinical Notes on Aging." The Committee is soliciting more articles and plans to continue this section. We would urge any member who has any interest in developing an article on related subjects to get in touch with the Committee.

In cooperation with the Protective Services Division of the Attorney General's Office, the Committee has finalized a brochure on adult abuse which will be printed in-house and furnished to the membership. The brochure will also be used in association with other organizations to focus attention on this significant problem. The Protective Services Division has offered to conduct seminars on this and related issues for concerned groups, and it is suggested that the membership keep this information in mind.

The Committee briefly considered Resolution Z (1987) dealing with the issue of implementation of outpatient DRGs, which is a provision of the Budget Reconciliation Act of 1986. It was learned that the AMA has been working closely with the Health Care Financing Administration over the past year to arrive at an amenable agreement on this issue, and it is projected that no action will occur in the near future.

The Committee expressed some interest in the scope and quality of geriatric training being provided to medical students and residents in Kentucky. This field is becoming increasingly important as the U.S. population ages, but it was suggested that inadequate attention or funding may be available for curriculum. The Committee plans to pursue this issue with the state's two medical schools and offer its assistance.

Along similar lines, the American Geriatrics Society is currently encouraging states to develop local affiliates. The Committee feels that it might play an appropriate role in this effort in order to promote geriatric medicine generally, and possibly to collaborate in CME activities.

The Committee also considered the issue of so-called "No Code" orders in nursing homes. While this might prove to be a controversial issue, there are practical concerns that do need addressing. Critically ill nursing home patients often are hospitalized when death is imminent, and this might not be appropriate medically, or in keeping with the family's wishes. Additionally, the cost specter arises because Medicare will pay for hospitalization but not for nursing home care. The Committee plans to give further attention to this and similar items for possible discussion in forums of allied groups and other interested individuals.

A final issue of concern noted was an incident where, apparently, the new adult protective services law may have been vigorously invoked. In this situation, one nursing home patient was injured by another. Under the new law, administrative personnel of the nursing home were indicted as Class D felons, which may possibly have been inappropriate. The Committee plans to follow this situation, as well as to work through the Board of Trustees to determine if any future involvement by KMA is warranted relating to liability concerns.

As Chairman, I would like to thank all of the Committee members for their interest and assistance.

John C. Wright, II, MD
Chairman

RECOMMENDATION:

1. The Committee on Care for the Elderly recommends that KMA endorse the concept of establishing a Kentucky affiliate of the American Geriatrics Society. If appropriate, the Committee on Care for the Elderly will assist in that effort and work in areas of mutual interest.

Recommendations, Reference Committee No. 3:

The Reference Committee reviewed the Report of the Committee on Care for the Elderly and its Recommendation that KMA endorse the concept of establishing a Kentucky Affiliate of the American Geriatrics Society; and further that if appropriate, the Committee on Care for the Elderly will assist in that effort and work in areas of mutual interest.

Reference Committee No. 3 recommends this report and its Recommendation be adopted.

Report of the Ad Hoc Committee on Professional Liability Insurance

Addendum to the Report of the Chairman, Board of Trustees

The two-year campaign of the Kentucky Medical Association to achieve legislative relief from the growing malpractice crisis was highly successful and resulted in the passage of a substantial package of tort reform and insurance regulatory legislation during the 1988 Kentucky General Assembly. House Bills 551 and 552, and House Concurrent Resolution 62 became effective July 15, 1988, and the key provisions of those enactments are summarized below.

HOUSE BILL 551

Joint and Several Liability

Requires that juries be instructed to determine the percentage of fault appropriate to each claimant, defendant, third-party defendant, and defendants settling out of court and then apportion each party's "equitable share in . . . in accordance with the respective percentages of fault."

Standards of Conduct for Punitive Damages

Recommends that in suits for punitive damages, the standard of evidence should be "clear and convincing" rather than based upon a "preponderance of evidence"; and the conduct involved must constitute oppression, fraud, or malice as defined in the proposal.

Collateral Source Rule

Requires that plaintiff or his attorney notify all parties known to have subrogation rights that an action has been filed. If the party with subrogation rights fails to intervene, those subrogation rights are lost. Further, the jury would be advised of the existence of collateral source payments, the amount paid by or on behalf of the plaintiff for such benefits, and the known subrogation rights of the collateral payors. The jury would then decide whether or not to offset the total award by the amount already paid by such sources.

Standards of Conduct for Officers and Directors of For-Profit Corporations

(a) Adopts standards of conduct and duties for officers and directors, and establishes that monetary damages may be awarded only upon "clear and convincing" evidence that the conduct was "willful, wanton, or in reckless disregard" of the interests of the corporation or its shareholders.

(b) Allows corporations, through shareholder action, to amend the articles of incorporation to assume greater responsibility for the liability of their directors.

Standards of Conduct for Officers, Directors, and Volunteers of Non-Profit Corporations and Charitable Organizations

(a) Adopts language almost identical to the provisions regarding the conduct of officers and directors of for-profit corporations. These provisions define standards of conduct for which officers and directors could not be held personally liable.

(b) Adopts language which provides that volunteers for nonprofit organizations, as defined under 501(c) of the Internal Revenue Code, should not be held personally liable unless the conduct falls substantially below standards generally practiced by persons performing similar duties. The organization itself, however, could be held liable for damages or injury resulting from negligent acts.

Municipal Tort Claims Act

Enacts a "Municipal Tort Claims Act" which contains the following:

(a) Applies to all state court actions in tort brought against any city.

(b) Limits the damages recoverable against a city to the amount of damages determined to have been caused by the city.

(c) Broadly defines "legislative, quasi-legislative, judicial, and quasi-judicial functions" and exempts cities from liability in performance of, or failure to perform, these types of functions.

(d) Authorizes periodic payments of large judgments which are not covered by liability or property insurance.

Confidentiality of Peer Review Records

Amends KRS 311.377 to clarify questions of confidentiality and liability of individuals participating in the medical peer review process.

Antitrust Immunity for Peer Review and Centralized Reporting of Liability Claims

Adopts provisions of the Health Care Quality Improvement Act of 1986, which establishes immunity from antitrust claims for good faith peer review; it also establishes centralized reporting of malpractice and disciplinary actions.

HOUSE BILL 552

Assure Availability of Insurance

All insurers licensed to write property and casualty insurance in Kentucky participate in the FAIR plan (fair access to insurance requirements) and pay assessments to the plan based upon a percentage of premiums voluntarily written in Kentucky. Amendments allow the Commissioner, if reasonable competition does not exist for certain lines of insurance, to amend the plan to provide insurance for those lines. An assessment of the participants would fund the program.

Self Insurance/Local Government Insurance/ Fictitious Group Statute

Reduces traditional barriers to permit more groups to self-insure; clarifies the authority by which local governments can procure insurance, including the use of revenue bonds. Repeals the fictitious group statute, which prohibited groups under common ownership or management from purchasing property, marine, or casualty insurance. Permits individuals to band together for the purpose of purchasing insurance, as well as self-insuring.

Extended Notification for Cancellation and Nonrenewal of Insurance

Amends the current statutory limitations (30 days) to require at least 75 days notice of intent to cancel or not renew property and casualty insurance.

Flex Rating Approaches

Establishes a flex rating system whereby rates could not increase or decrease by more than 25% without filing the rates and obtaining prior approval from the Commissioner.

Kentucky Claims Experience

Requires insurors to annually provide the Commissioner of Insurance information which would identify to what extent Kentucky's experience is being used in determining rates charged in Kentucky.

Consent to Rate and Coverage

Requires agents to sign a "consent to rate" form with the insured and sign an affidavit that restrictions of the policy have been thoroughly explained to the purchaser.

Closed Claim Information

Requires state government to gather information on insurance claims and civil litigation to determine now and for the future the extent and nature of problems. Requires the insurance industry to provide information to the Commissioner of Insurance who would annually compile the information and submit a report to the Governor and General Assembly.

Insurance Policy Simplification

Authorizes the Commissioner of Insurance to set standards regarding the readability and intelligibility of insurance policies.

Surplus Lines Policies

Requires surplus lines to advise the purchaser, in bold print on the face of the policy, that insurance purchased through surplus lines does not carry with it the protection and benefits of the Insurance Guaranty Association.

Insurance Settlement

Assists insureds by requiring insurors to settle claims within a reasonable time and manner. Failure to act accordingly could result in the company paying interest as well as attorney fees.

Unfair Claims Settlement Practices Act

Gives consumers of insurance the benefit of the Act, upon any violation, and recommends that the Commissioner be permitted to reprimand or fine a violator for a single violation of the Act.

Insurance Consumer's Advisory Council

Creates an Insurance Consumer's Advisory Council to monitor the sale and pricing of insurance in Kentucky and recommend changes in the law to the Commissioner, Governor, and the General Assembly on behalf of the consumers of insurance. Permits the Advisory Council to review consumer complaints.

Increased Funding/Department of Insurance

Requires increased regulatory responsibility be assumed by the Department; permits the Commissioner to assess insurors to cover additional regulatory expenses. Permits the Department of Insurance to carry over funds and grants authority to set fees by regulation.

HOUSE CONCURRENT RESOLUTION 62

Frivolous Lawsuits, Rule 11, and Certificates of Merit

Recommends the Kentucky Supreme Court adopt a measure providing for a "certificate of merit." Within 90 days of filing a lawsuit, the plaintiff or attorney would file with the Court a certificate stating that the case has merit and that an expert witness will testify in support of the allegations. The attorney for the defense must also file a similar certificate. Failure to file the certificates by either party would serve as grounds for the Court to dismiss the complaint or counterclaim.

Offer of Judgment

Recommends to the Supreme Court of Kentucky that Civil Rule 68 be amended to provide greater incentives for its proper use. By directing that all costs, including attorney fees, be awarded against the party failing to accept a reasonable offer of settlement, plaintiffs and defendants alike would avail themselves of the opportunity to evaluate the case and move expeditiously toward resolution before the parties incur substantial expenses often associated with litigation.

Remittitur and Additur

Recommends altering Civil Rules to allow the Court to review an award and to raise or lower it if the Court believes the amounts are excessive or inadequate. Presently, the only option available is to grant a new trial where the Court finds the damages either "excessive or inadequate . . . appearing to have been given under the influence of passion or prejudice or in disregard of the evidence or the instructions of the Court."

COMMENTARY

While certainly not an overnight cure, the 1988 reforms will be helpful over the long term. When compared to other state reforms, KMA's package fares very well.

Unfortunately, several other measures we advocated were not adopted. The Constitutional Amendment to permit the Kentucky General Assembly to cap noneconomic awards was narrowly defeated in the Senate Democratic Caucus. The proposal to require structured payments for future loss of wages, medical expenses, and pain and suffering was unceremoniously dumped from the proposed package. The proposal to reduce the statute of limitations for minors was introduced by KMA in the Senate. However, that bill failed to receive

a hearing. Finally, the proposal to remove malpractice cases from the present court system and place them in a "Workers' Compensation" or "no-fault" setting was not enacted, although a special subcommittee recommended the concept be studied during the Interim.

It is important that you understand why some of the proposals we supported were not enacted. Some additional background will be helpful. First of all, the proposal to modify the Kentucky Constitution came very close to being adopted. Your overwhelming response to KMA's request to write Senators almost succeeded. We did have the support of Senate Leadership, and we believe that same support will be there next Session. However, the Governor's lottery proposal and the drive to adopt the Gubernatorial succession amendment distracted from our efforts and contributed to the defeat of SB 43. Once again, we will need to convince the majority party that altering Section 54 of the Kentucky Constitution should be included as one the Senate's two amendments.

The structured settlement proposal surprisingly served as the "lightning rod" for opposition to tort reform. We found little or no support for this proposal, not only among members of the KGA, but business and professional allies as well. There is a perception that insurance companies are the direct beneficiary of structured settlements, and physicians would benefit only secondarily, if at all. Many legislators questioned whether these savings would ever be passed along.

As in 1986, the recommendation for reducing the statute of limitations for minors again created a furor. First of all, we could not demonstrate nor produce definite evidence that passage of this legislation would result in a savings for physicians who practice obstetrics. The problem is generally perceived by legislators to be more psychological than real. However, KMA objected to this notion, pointing out that cases in this area are often big dollar claims. Despite actuaries' reluctance to place price tags on such claims, we believe substantial reserves are being set aside to deal with them.

Any attempt to reduce the statute of limitations for minors seems to prompt concern about Kentucky's stringent one-year statute of limitations for medical malpractice. Currently many, if not all, statutes of limitation are under attack. In a recent case, *Tabler v. Wallace*, the Kentucky Supreme Court found a statute of limitations dealing with architects, builders, and engineers unconstitutional. That statute is quite similar to the one dealing with medical malpractice, and the case is certainly unsettling for medicine. During the 1988 Session, critics argued that Kentucky is one of only three or four states with a one-year statute. They contend that any proposal to reduce the statute of limitations for children should be accompanied by raising the general statute to a minimum of two years. Finally, this proposal must be referred to the Judiciary-Civil Committee, where all six members in the Senate are attorneys as are 11 of 17 committee members in the House.

The no-fault or Workers' Compensation type proposal to replace the present medical liability fault-based legal system received a substantial hearing. It was not overwhelmingly received, but the seed has been planted, and we believe this concept has merit. There is a growing consensus that a system such as that advocated in the Wedekind proposal, introduced in the 1988 Session as House Bill 558, will eventually be adopted. While tort reform appears to slow the frequency and severity of lawsuits, it is clear that a move away from the adversarial fault-based system is certainly attractive.

There will be several roadblocks to reform in 1990 that did not exist in 1988. First of all, many people believe the liability crisis is over. Secondly, the legislative Task Force, which served as a vehicle for our reform proposals, has completed its work and has disbanded. Thirdly, the General Assembly, having once addressed an issue on a massive scale (as it did the liability issue), believes that subject need not be revisited until the reforms adopted have had an opportunity to work. Finally, the assertion persists that the crisis was artificially created to permit major insurance and reinsurance companies to refill their coffers. Like it or not, we are closely identified with the insurance industry and specifically KMIC, which we parented. KMIC and other malpractice insurors will be closely watched over the next two years, and laws enacted by the 1988 KGA will require extensive reporting of claims, losses, profits, etc., to the General Assembly. These reports will have a dramatic impact upon our ability to achieve passage of reform legislation.

Despite these obstacles, we must continue to seek legislative relief from the crisis.

The KMA Ad Hoc Committee on Professional Liability Insurance recommends that KMA continue to seek legislation to:

1. Alter or eliminate Section 54 of the Kentucky Constitution;
2. Permit structured settlements in lieu of lump sum payments;
3. Reduce the statute of limitations for minors;
4. Reform the present fault-based system of medical liability to a no-fault or Workers' Compensation system.

Additionally, we should strive for answers to the expert witness dilemma, consider legislation involving brain injured newborns (i.e., Virginia law), and be alert to trends in liability reform. We will carefully review any new proposal or idea that is offered which might help resolve the liability problem. We will keep an open mind and be ready to take advantage of reform legislation that meets Kentucky's Constitutional restraints.

We are carefully monitoring the future of Court rules proposed by the 1988 KGA contained in HCR 62. If the Court fails to adopt the rule recommendations, we will consider legislation to accomplish the same or similar provisions contained in HCR 62.

Ours is not an easy task. The Kentucky Constitution remains a formidable obstacle to meaningful reform. Any legislation that caps awards or which might be construed as

limiting access to the Courts as "special" legislation is, at best, suspect and risks running afoul of the Constitution. Stable and meaningful solutions will require time. We should not look upon this Campaign as just a 1988 or 1990 effort. We need to continue the quest for reform and be aware of causative factors and parties who brought us to this critical situation. We must carefully monitor the legal system and the insurance industry, the critical elements in the complicated malpractice puzzle. Additionally, we must educate the public to the point where they are aware that a system which absorbs 68 cents of the dollar and returns only 32 cents to the injured party is ineffective and unconscionable.

Finally, it is crucial that we keep our own house in order. We need to continue our support for strengthening the Medical Practice Act and maintain a strong and vigilant Judicial Council and Impaired Physicians Committee. We must be above reproach and participate in all aspects of peer review, various claims prevention seminars and workshops, mindful that our patients rely upon our integrity and our professional training, judgment, and experience to keep them from harm.

Your support in 1988 was unprecedented and has made an indelible mark upon members of the General Assembly. While we are presenting a statewide plan of action for the next two years to achieve additional reform, it is just as important that each county society and member work on a local level with individual legislators.

On behalf of the Ad Hoc Committee on PLI, we present the following plan for your consideration and recommend the adoption of the PLI Campaign Plan — 1988-1990. Thank you for your patience and hard work in 1988.

PLI Campaign Plan — 1988-1990

A. Governmental Activities

1. Kentucky General Assembly

a. KGA Leadership and Key Member Visits

We will continue to build personal relationships with members of the Kentucky General Assembly. Emphasis will be placed on visits by Officers and staff to House and Senate leadership and the chairmen and members of key House and Senate committees. Key committees will be closely monitored by KMA staff with timely reports made to Officers and periodic updates to the membership.

b. Public Relations

KMA will continue to work with Kentucky's outstanding public relations firms on an as-needed basis to build legislative, public, and physician support for reform. We will continue using material previously developed, update material, and prepare new material as needed to fulfill our objectives.

c. Key Contact System

The KMA Key Contact System is in continuous evolution. The System will be upgraded as appropriate, and timely information and packets will be provided to physicians serving as Key Contacts.

d. Contacts on Issues

In 1988, KMA leadership directed that "Legislative Committee Bulletins" be sent to all members. We plan to continue these mailings in conjunction with the 1990 Legislative Session.

e. Distribution of Printed Material

KMA will continue to keep the General Assembly informed about liability issues. Policy statements, fact sheets, updates on the effect the crisis has on care delivery, etc., are illustrative of the types of material distributed periodically. Brochures outlining the problem will be available to those members who wish to provide them to their patients. Key Contact packets will again be developed and forwarded to physicians.

f. Involvement in KMA Meetings and Activities

Continued involvement by KGA members in Association activities and programs ensures an enhanced awareness of KMA's position on issues and affords an opportunity to create good working relationships between physicians and legislators. Building such rapport will continue to be an integral part of our plan for effecting legislative change.

g. KEMPAC Activities

KEMPAC demonstrated its willingness to get into the middle of the liability problem and to support candidates for election whose philosophies were closely allied to business and public interest. KEMPAC is showing an increasing interest, not only in the legislative arena, but in the judicial elections as well.

h. 1986 House of Delegates Policy on Liability

The 1986 House of Delegates enacted several recommendations for liability reform. In 1988 we were able to fulfill several of those directives. However, four proposals will be reintroduced in the 1990 Session to meet House directives. These four are: alter or delete Section 54 of Kentucky's Constitution, reduce the statute of limitations for minors, establish periodic payments in lieu of lump sum payments, and propose reforms of the fault-based system by utilizing a no-fault or Workers' Compensation system.

Additionally, we shall continue to pursue problems relating to expert witness, legislation relating to brain injured infants and other proposals that develop which may assist in resolving the liability problem.

2. Congress/Federal Administration

a. Kentucky Congressional Delegation

b. AMA Liaison

The KMA Committee on National Legislative Activities and our excellent liaison with the AMA and others, provide KMA with effective representation at the national level. The Kentucky Congressional Delegation responds well to organized medicine's concerns, and we plan to articulate these in an even stronger way when we visit Washington in 1989. This visit, culminating in the Washington Dinner, will provide an opportunity to demonstrate that KMA is interested in reform initiatives at both the state and national levels.

3. Administration

a. Governor's Office

While the Governor took a hands-off approach in 1988

with regard to tort reform, it is important to remind members that the Chief Legislative Liaison with the Kentucky General Assembly was primary staff person to the special Kentucky Insurance and Liability Task Force, which presented the recommendations subsequently adopted by the 1988 KGA. We plan to continue working with the Governor's office.

b. **Cabinet for Human Resources**
Budgetary restrictions and the CHR's recognition that the liability crisis contributes to health costs and denies access to care for the indigent, make CHR a natural ally. We should work very closely with members of CHR staff on matters relating to reform which they can support.

c. **Attorney General's Office**
We plan to work with the Attorney General's office and to present our concerns relating to the public and the profession and seek support for reform from the Attorney General.

d. **Lieutenant Governor's Office**
The Lieutenant Governor was very helpful in our efforts in 1988, and we shall continue working with that office in the Interim.

B. KMA Membership Education and Involvement

1. **Information & Roles**
Success in 1988 was established by involving every member in the process. That included weekly legislative updates with specific directions on how a member could assist in the effort. We trust this involvement will continue. In addition, we plan to update the "Legislative Handbook" which goes to all KMA members and provides them with the appropriate information to work with their elected representatives.

2. **Staff**
Additional outside lobbying assistance was utilized in the 1988 Session and will be retained through the 1990 Session. In addition, a member of KMA staff is specifically assigned to the liability issue and will continue to provide ongoing continuity to the legislative, public, and membership Campaign. Other members of KMA staff will assist in the Campaign as needed.

3. **KMA Annual Meeting (1989)**
An open session on liability insurance will be conducted during the 1989 Annual Meeting. The session will update members on the Campaign, define plans for the 1990 KGA, and provide materials and background information to effectively lobby KMA's proposals.

A special Reference Committee hearing on Monday afternoon (1989) will provide members the opportunity to use information gained from the open session. KMA leadership will be present to further explain the Campaign Plan.

The KEMPAC dinner, both in 1988 and 1989, will be the third step in this "educational process" and will relate more to the political concerns incident to effecting change in the liability area. It is important to invite every state legislator to the KEMPAC dinner to thank them for their past support and to discuss the upcoming KGA.

4. **KMA Hospital Medical Staff Section**
We will request that time be set aside at the 1989 KMA-HMSS Annual Meeting for a presentation on KMA's legislative proposals. In addition, we shall request that periodic updates on KMA's Campaign be included in the "HMSS Newsletter."

5. **Hospital Medical Staff Meetings**
Hospital medical staff meetings will be utilized as an effective tool for enhancing communication between KMA and physicians on the PLI issue. Hospital staff meetings also provide us an opportunity to expose KMA activity to nonmembers and encourage their participation in organized medicine. These meetings can augment county medical society and Trustee District meetings, and our appearance could be scheduled at a time when leadership and staff are already in an area to visit KGA leadership and members. Presentations of a similar nature can also be made before the staff of some of the larger clinics throughout the state.

6. **County Society Meetings**
In those counties having an organized society which meets on a regular basis, we plan to meet with them and provide assistance to them in developing a local legislative program.

7. **Trustee District Meetings**
Trustee District meetings will provide a forum for District physicians to discuss KMA's PLI program and to assist in implementing the program. Presentations before hospital medical staffs, county societies, and Trustee Districts should outline the realities of the legislative process, and KMA leadership can stress the need for physician involvement in the legislative arena. This can be expanded to cover specific tort reform measures or other matters of interest, depending on the situation.

8. **Auxiliary**
The AKMA was extremely involved in the 1988 Legislative Session. Once again, we would recommend that the Auxiliary continue the Key Contact Phone Bank, Auxiliary legislative contacts, and its annual visit to the Capitol.

9. **Surveys, Data Collection, Preparation of Speeches & Printed Materials**
We conducted extensive surveys during the 1986-1988 Campaign, and we believe the results can still be utilized. In addition, we will periodically update the membership surveys to determine practice patterns as they are affected by the liability problem. We will continue to gather materials, develop slide presentations, and have sample speeches for Officers and membership so that we can address the issue at any time upon request. Legislative testimony, packets, and VCR and audio tapes will be developed as they are needed.

10. **Liaison, Communication, and Coordination**
We will maintain communication with specialty groups, county societies, hospital medical staffs, medical executives, and other groups aligned with KMA on the PLI proposals. We will be available to speak to these groups or to work with them in areas where they have a special interest or need special assistance.

11. **Visitation Program**
When appropriate, Officers and staff will interact with other states, AMA, and national specialty groups, and attend meetings we feel may be useful to our Campaign. We particularly plan to maintain close liaison with surrounding states, as Kentucky legislators place greater emphasis on their activities and consider local or nearby reforms more apropos than those distant from Kentucky.

12. **KMA Conference**

While the Committee does not propose a specific conference to discuss the PLI issue, it is recommended that whenever the opportunity presents itself, the PLI issue should be placed on the agenda.

13. **Legislative Conference**
We recommend that a Legislative Conference be conducted in January of 1990 for KMA Key Contacts, Officers, and members of the Board of Trustees, specialty group officers, county society officers, Auxiliary officers, KEMPAC Board members, other interested members, and staff. This Conference should be held in Frankfort utilizing legislative leadership and staff to complement KMA Officers and others who will be on the program.

C. Private Sector Initiatives

1. Tort Reform Association of Kentucky (TRAK)

a. Influence Public and Legislative Opinion
The Tort Reform Association of Kentucky was a very effective tool preceding and during the 1988 Session. Over 30 major businesses and associations participated and became dues-paying members. We recommend that KMA maintain its present level of support for TRAK as a major vehicle for tort reform. Industry, business, and association support is crucial to our Campaign.

b. TRAK Leadership
We feel the core leadership should be maintained as it was very effective in 1988. However, we would like to see membership expanded without altering the effectiveness of the group.

c. TRAK Membership Fees
According to the most recent financial report, adequate funds are available to continue TRAK and its programs.

2. Allied Health Groups
We received excellent support from allied health groups during 1988 and will build on that relationship in the coming year. Hospitals, nursing homes, dentists, pharmacists, and nurses joined TRAK and worked with us during the Session.

3. The Legal Profession

a. KBA Liaison
We plan to continue activity in this area and will utilize the KMA-KBA Physician-Attorney Liaison Committee as a vehicle for communication with KBA. Members need to know that there is a distinct difference between the Kentucky Bar Association and the Kentucky Association of Trial Attorneys.

b. Judge-made Law
We will closely monitor the Kentucky Supreme Court as it considers House Concurrent Resolution 62 which petitions the Court to establish rules relating to Certificate of Merit, Remittitur and Additur, and Offer of Settlement rules. Should the Court refuse to act, then KMA will consider introducing legislation to accomplish these objectives.

D. Public Education

1. KMA Public Relations Campaign
KMA will continue its relationship with the two PR companies utilized during the 1988 Campaign. Public Relations will be involved in dealing with the Legislature, the public, KMA members, and other segments of the private sector. We will continue integrating our PR efforts with TRAK and working with other major groups involved in tort reform.

However, we will maintain our separate liability campaign and the ability to move unilaterally if necessary or if the interest of other groups in the liability issue wanes.

We will provide brochures to physicians upon request to distribute to their patients. Various presentations will be developed for use by leadership and members who wish to speak to groups regarding the liability program.

Wally O. Montgomery, MD
Chairman

RECOMMENDATIONS:

1. The KMA Ad Hoc Committee on Professional Liability Insurance recommends that KMA continue to seek legislation to:
   a. Alter or eliminate Section 54 of the Kentucky Constitution;
   b. Permit structured settlements in lieu of lump sum payments;
   c. Reduce the statute of limitations for minors;
   d. Reform the present fault-based system of medical liability to a no-fault or Workers' Compensation system.
2. The KMA Ad Hoc Committee on Professional Liability Insurance recommends that the PLI Campaign Plan — 1988-1990 be adopted.

Report of the Chairman, Board of Trustees
Recommendation No. 2 Only

2. The Board of Trustees has approved the continuing PLI Campaign Plan as outlined in the Report of the Ad Hoc Committee on Professional Liability Insurance, and urges House of Delegates' concurrence.

Recommendations, Reference Committee No. 3:

The Reference Committee reviewed the Report of the Chairman, Board of Trustees, Recommendation #2 (page 5.15) and the Report of the Ad Hoc Committee on Professional Liability Insurance, **only**, and its recommendations. The Reference Committee commends the Ad Hoc Committee on PLI for an excellent report.

Reference Committee No. 3 recommends that Recommendation 1 (d), which currently reads, "Reform the present fault-based system of medical liability to a no-fault or Workers' Compensation system" be amended to read as follows: "Reform the present fault-based system of medical liability to a no-fault *plan* or *program similar to the* Workers' Compensation system."

Reference Committee No. 3 further discussed Recommendation 2, which is the Association's PLI Campaign Plan for 1988-1990, as well as Recommendation #2 of the Chairman of the Board's Report calling for approval of the PLI Campaign Plan. The Reference Committee would encourage

each member of the House of Delegates to thoroughly read the PLI Campaign Plan for 1988-1990, encompassed in pages PLI.11 through PLI.20, and be ready to actively participate in the implementation of this Plan.

Reference Committee No. 3 recommends that the Report of the PLI Committee and its two recommendations, as amended, along with Recommendation #2 (page 5.15) of the Chairman of the Board's Report, be adopted.

Resolution K

Enforcement of DUI Laws
Resident Physician Section

WHEREAS, 6,238 people were killed or injured on Kentucky highways in 1987 due to alcohol-related accidents, and

WHEREAS, physicians throughout the state of Kentucky see first-hand the traumatic consequences produced by individuals driving under the influence of alcohol, and

WHEREAS, Kentucky's current DUI legislation permits a wide range of penalties for first-time and repeat offenders, now therefore be it

RESOLVED, that KMA support the stricter enforcement of penalties provided in current Kentucky laws concerning driving under the influence of alcohol, and be it further

RESOLVED, that KMA ask the appropriate government agencies to undertake a public awareness campaign of the current penalties for DUI.

Recommendations, Reference Committee No. 3:

Your Reference Committee reviewed Resolution K, Enforcement of DUI Laws, introduced by the Resident Physicians Section. Several members spoke in support of this Resolution.

Reference Committee No. 3 recommends that Resolution K be adopted.

Resolution L

Availability of Obstetrical Services
J. Gregory Cooper, MD, Cynthiana

WHEREAS, affordable, high-quality obstetrical care should be available to all women in Kentucky, and

WHEREAS, high-quality obstetrical training must continue in Kentucky residency programs to meet the needs of the citizens of the Commonwealth, and

WHEREAS, obstetrical services have traditionally been provided by family practitioners and obstetricians, and

WHEREAS, the cost and availability of professional liability insurance now threaten the availability of obstetrical care in many areas of Kentucky, now therefore be it

RESOLVED, that the Kentucky Medical Association continue its pursuit of legislation to address the liability insurance issue, and be it further

RESOLVED, that the Kentucky Medical Association appoint a task force on obstetrical care to:

1. Meet with the directors of Kentucky family practice and obstetrical residency programs to discuss the status of obstetrical training in those programs and encourage family practice residency programs to provide obstetrical training as an integral part of their family practice programs;
2. Encourage Kentucky's medical schools to continue the enhancement of the quality of obstetrical care available through post-residency continuing education programs; and
3. Develop and recommend actions for consideration by the KMA Board of Trustees to urge and encourage that professional liability insurance coverage be available to all qualified physicians who provide obstetrical care; and be it further

RESOLVED, that this task force be asked to report to the House of Delegates at its 1989 meeting on the results of these activities.

Recommendations, Reference Committee No. 3:

Reference Committee No. 3 reviewed Resolution L, Availability of Obstetrical Services, introduced by J. Gregory Cooper, MD, Cynthiana, and heard testimony from a number of members.

Reference Committee No. 3 recommends the adoption of Resolution L.

Resolution N

Warnings Against Use of Alcohol During Pregnancy
Fayette County Medical Society

WHEREAS, fetal alcohol syndrome and fetal alcohol effects may result from the use of alcohol during pregnancy, and

WHEREAS, the incidence of fetal alcohol syndrome may result in one in 600 births, and

WHEREAS, the American Medical Association has recommended total abstinence during pregnancy, now therefore be it

RESOLVED, that the Kentucky Medical Association seek appropriate legislation in the Kentucky General Assembly to require, in all places where alcohol is sold, the posting of warning signs that drinking alcoholic beverages during pregnancy can cause birth defects.

Recommendations, Reference Committee No. 3:

The Reference Committee reviewed Resolution N, Warnings Against Use of Alcohol During Pregnancy, introduced

by the Fayette County Medical Society, and recommends it be adopted.

Resolution P

Physician Certification of Cause of Natural Death
Bell County Medical Society

WHEREAS, accurate determination of the cause of death is essential for the accumulation of accurate mortality statistics, and

WHEREAS, unattended deaths are certified by coroners, who are usually neither physicians nor persons familiar with the deceased's medical conditions, now therefore be it

RESOLVED, that when the coroner determines that death was due to natural causes, the cause should be determined by a physician after appropriate investigation. This physician should be the pathologist if an autopsy was performed. Otherwise, the physician should be one familiar with the patient's condition. If no such physician is available, the coroner's office should utilize the services of one employed to evaluate those cases not under the care of any physician, and be it further

RESOLVED, that the Kentucky Medical Association work for changes in Kentucky law to require physician certification on the cause of natural deaths.

Recommendations, Reference Committee No. 3:

Reference Committee No. 3 reviewed Resolution P, Physician Certification of Cause of Natural Death, introduced by Bell County Medical Society, and heard a number of comments regarding the Resolution. All the testimony received was in opposition to the passage of Resolution P. No representative from the Bell County Medical Society was present, and it was the consensus that the situation involving certification of death is improving in Kentucky and that passage of this Resolution would not be helpful. The Reference Committee felt that to require every coroner in the state to be a physician would be unrealistic at the present time.

Reference Committee No. 3 recommends that Resolution P be rejected.

Resolution T

Compulsory Chiropractic Health Insurance Coverage
Daviess County Medical Society

WHEREAS, chiropractic insurance has been mandated by the Kentucky Legislature as a requirement for all health insurance policies sold in the Commonwealth, and

WHEREAS, a large number of people do not believe in, subscribe to, or desire chiropractic treatment, and

WHEREAS, such mandated chiropractic "health" insurance is an additional expense for which they have no chance of realizing a benefit, now therefore be it

RESOLVED, that the Kentucky Medical Association seek legislation in the next regularly convened Kentucky General Assembly that permits a waiver of chiropractic coverage under health insurance policies issued in Kentucky.

Recommendations, Reference Committee No. 3:

Reference Committee No. 3 reviewed Resolution T, Compulsory Chiropractic Health Insurance Coverage, introduced by the Daviess County Medical Society, and heard considerable testimony. The Reference Committee is aware of legal action brought against the AMA by chiropractors and that the Medicare and Medicaid Programs include coverage for chiropractic services. In view of these matters, it appears that any change from compulsory coverage is not likely. The Reference Committee feels that consumers should have the option of excluding this coverage and, therefore, feels the Resolution should be approved.

Reference Committee No. 3 recommends that Resolution T be adopted.

Resolution U

Professional Liability Insurance Task Force
KMA Board of Trustees

WHEREAS, professional liability insurance is the number one priority and an ongoing issue of major concern to the Association, and

WHEREAS, the Task Force on Professional Liability Insurance was created in 1987 to bring many points of view together to address the issue of professional liability insurance, and

WHEREAS, KMA's Immediate Past President, Richard F. Hench, MD, Lexington, represented the Kentucky Medical Association on the Task Force, along with Carl L. Wedekind, President of the Kentucky Medical Insurance Company, and

WHEREAS, both individuals contributed a major amount of their time on behalf of the physicians of Kentucky in 19 meetings over 18 months of the Task Force, and

WHEREAS, Doctor Hench's involvement as a KMA representative required much coordination with the Association and was directly responsible for influencing the development of a Tort Reform Package supported by the Kentucky Medical Association, much of which became law in the 1988 Kentucky General Assembly, now therefore be it

RESOLVED, that the KMA House of Delegates does hereby commend and applaud the efforts of Richard F. Hench, MD, Lexington, and Carl L. Wedekind, Louisville, for their unselfish commitment of time and effort representing the interests of Kentucky physicians on the Professional Liability Insurance Task Force.

Recommendations, Reference Committee No. 3:

The Reference Committee reviewed Resolution U, Professional Liability Insurance Task Force, introduced by the Board of Trustees, in commendation of Richard F. Hench, MD, and Carl L. Wedekind, for their involvement with the Kentucky Insurance and Liability Task Force. There was unanimous support for the Resolution from those members in attendance at the meeting.

Reference Committee No. 3 recommends adoption of Resolution U.

Resolution X

KMA Committee on State Legislative Activities
KMA Board of Trustees

WHEREAS, the Kentucky Medical Association set passage of a comprehensive tort reform package as a major priority in 1988, and

WHEREAS, a comprehensive plan to accomplish that reform was developed by the KMA Committee on State Legislative Activities and implemented through the considerable efforts of many physicians and spouses across the state, and

WHEREAS, those efforts are viewed as being one of the most significant efforts made by the Association in recent years and were, for the most part, highly successful, now therefore be it

RESOLVED, that the KMA House of Delegates does hereby commend and applaud the efforts of the KMA Committee on State Legislative Activities and its Chairman, Wally O. Montgomery, MD, Paducah, for a plan well thought out and executed, and voices its appreciation to the Committee and those physicians and spouses across the state who worked so diligently for the passage of this legislation.

Recommendations, Reference Committee No. 3:

Reference Committee No. 3 reviewed Resolution X, KMA Committee on State Legislative Activities, introduced by the Board of Trustees, and received unanimous support from those in attendance for the commendation of the KMA Committee on State Legislative Activities and its Chairman, Wally O. Montgomery, MD, as well as other members and spouses who worked so diligently for the passage of KMA's tort reform package during the 1988 Kentucky General Assembly.

Reference Committee No. 3 recommends the adoption of Resolution X.

Resolution Z

Referral of Preoperative and Postoperative Cataract Surgical Patients
KMA Board of Trustees

WHEREAS, preoperative and postoperative care of cataract surgical patients has traditionally and appropriately been considered the practice of medicine, and

WHEREAS, quality of care, particularly in the area of eye care, is jeopardized by the authorization of nonphysician practitioners to perform preoperative and/or postoperative surgical care for cataract patients, and

WHEREAS, this practice is being addressed at the Federal level, especially in cases where ophthalmologists remove cataracts and fail to provide surgical followup, and

WHEREAS, the operating surgeon is best trained to provide postoperative care to assure visual restoration following cataract surgery, therefore be it

RESOLVED, that the Kentucky Medical Association recommends to the Kentucky Board of Medical Licensure that, after due consideration, it prohibit or otherwise declare inappropriate the practice in which cataract surgery patients receive their preoperative and/or postoperative care from nonophthalmologists.

Recommendations, Reference Committee No. 3:

Reference Committee No. 3 reviewed Resolution Z, Referral of Preoperative and Postoperative Cataract Surgical Patients, introduced by the Board of Trustees.

Reference Committee No. 3 recommends the adoption of Resolution Z.

Resolution DD

Carrier Influence on Medical Practice
KY Society of KOGS — KY Section of ACOG

WHEREAS, the appropriate medical care of a patient is best determined by that patient in conjunction with advice from his or her physician, and

WHEREAS, the role of a third-party payor is to reimburse the patient for expenses incurred in receiving appropriate medical care, and

WHEREAS, a number of third-party carriers or payors for health claims have begun to interfere in the ability of a physician in the ability of an appropriate medical decision for the patient, and

WHEREAS, this is effectively allowing an insurance company to dictate the practice of medicine, and

WHEREAS, this is an unacceptable intrusion into the physician and patient relationship, and

WHEREAS, this places the patient at the risk of not having insurance benefits for which she has paid, or receiving suboptimal medical care, and

WHEREAS, one example of this is the mandated trial of labor in all patients with previous cesarean sections regardless of the patient's wishes or the physician's advice, now therefore be it

RESOLVED, that the Kentucky Medical Association and its Board of Trustees petition the Insurance Commissioner of the state of Kentucky and if necessary, introduce legislation in the 1990 State Legislature to require that insurance carriers do not have the ability to dictate to a physician or to the patient the advisability of a medical procedure or care.

Recommendations, Reference Committee No. 3:

Reference Committee No. 3 reviewed Resolution DD, Carrier Influence on Medical Practice, introduced by KY Society of KOGS — KY Section of ACOG, and recommends that the following substitute wording be adopted in place of the existing "Resolved":

"RESOLVED, that the Kentucky Medical Association and its Board of Trustees petition the Insurance Commissioner of the state of Kentucky and, if necessary, seek legislation in the 1990 State Legislature that would prevent insurance carriers from dictating medical decisions relating to medical procedures or patient care.

Reference Committee No. 3 recommends the adoption of the Substitute Resolution in lieu of Resolution DD.

The motion was seconded from the floor and carried. Resolution DD, Adopted as amended, reads as follows:

WHEREAS, the appropriate medical care of a patient is best determined by that patient in conjunction with advice from his or her physician, and

WHEREAS, the role of a third-party payor is to reimburse the patient for expenses incurred in receiving appropriate medical care, and

WHEREAS, a number of third-party carriers or payors for health claims have begun to interfere in the ability of a physician in the ability of an appropriate medical decision for the patient, and

WHEREAS, this is effectively allowing an insurance company to dictate the practice of medicine, and

WHEREAS, this is an unacceptable intrusion into the physician and patient relationship, and

WHEREAS, this places the patient at the risk of not having insurance benefits for which she has paid, or receiving suboptimal medical care, and

WHEREAS, one example of this is the mandated trial of labor in all patients with previous cesarean sections regardless of the patient's wishes or the physician's advice, now therefore be it

RESOLVED, that the Kentucky Medical Association and its Board of Trustees petition the Insurance Commissioner of the state of Kentucky and if necessary, seek legislation in the 1990 State Legislature that would prevent insurance carriers from dictating medical decisions relating to medical procedures or patient care.

Resolution EE

Noninsurance Assets
KY Society of KOGS — KY Section of ACOG

WHEREAS, despite a number of efforts to address the professional liability problem in the Commonwealth of Kentucky, instituted by a number of organizations, including the Kentucky Medical Association, and

WHEREAS, despite some leveling off on a temporary basis of the number of claims and awards, and

WHEREAS, this has not yet been accompanied by a leveling off of rates for malpractice insurance, and

WHEREAS, despite the cost of malpractice insurance, adequate insurance to protect against catastrophic, neurologically damaged patients involved in lawsuits is unavailable at any cost since regardless of the amount of coverage, damages claimed can be in excess, and

WHEREAS, the threat of an excess judgement over liability coverage in many instances may effectively blackmail an innocent physician into settling into pushing his insurance company to settle because of the risk of losing personal assets by the luck of the draw of the jury or judge, and

WHEREAS, this is a significant factor in the unwillingness of many physicians to fight a case in court despite their knowledge and evidence which strongly would prove their innocence in most instances, and

WHEREAS, this is a problem which affects not only Kentucky physicians, but also attorneys and other professionals dealing with the public who may be faced with large damage claims, now therefore be it

RESOLVED, that the Kentucky Medical Association, in conjunction with other professional organizations, introduce into the Kentucky Legislature, and lobby for its passage, legislation which would protect the personal assets of the retirement plan, home, etc., from claims in a professional liability award in the state of Kentucky if the physician maintains a legislatively mandated minimum level of professional liability insurance.

Recommendations, Reference Committee No. 3:

The Reference Committee reviewed Resolution EE, Noninsurance Assets, introduced by the KY Society of KOGS — KY Section of ACOG, and recommends the Resolution be amended by deleting the words in the last two lines of the "Resolved" beginning with "if" and ending with "Insurance." The revised "Resolved" would then read as follows:

"RESOLVED, that the Kentucky Medical Association, in conjunction with other professional organizations, introduce into the Kentucky Legislature and lobby for its passage, legislation which would protect the personal assets of the retirement plan, home, etc., from claims in a professional liability award in the state of Kentucky [*if the physician maintains a legislatively mandated minimum level of professional liability insurance*]."

Reference Committee No. 3 recommends that Resolution EE be adopted as amended.

The motion was seconded from the floor and carried. Resolution EE, Adopted as amended, reads as follows:

WHEREAS, despite a number of efforts to address the professional liability problem in the Commonwealth of Kentucky, instituted by a number of organizations, including the Kentucky Medical Association, and

WHEREAS, despite some leveling off on a temporary basis of the number of claims and awards, and

WHEREAS, this has not yet been accompanied by a leveling off of rates for malpractice insurance, and

WHEREAS, despite the cost of malpractice insurance, adequate insurance to protect against catastrophic, neurologically damaged patients involved in lawsuits is unavailable at any cost since regardless of the amount of coverage, damages claimed can be in excess, and

WHEREAS, the threat of an excess judgement over liability coverage in many instances may effectively blackmail an innocent physician into settling into pushing his insurance company to settle because of the risk of losing personal assets by the luck of the draw of the jury or judge, and

WHEREAS, this is a significant factor in the unwillingness of many physicians to fight a case in court despite their knowledge and evidence which strongly would prove their innocence in most instances, and

WHEREAS, this is a problem which affects not only Kentucky physicians, but also attorneys and other professionals dealing with the public who may be faced with large damage claims, now therefore be it

RESOLVED, that the Kentucky Medical Association, in conjunction with other professional organizations, introduce into the Kentucky Legislature, and lobby for its passage, legislation which would protect the personal assets of the retirement plan, home, etc., from claims in a professional liability award in the state of Kentucky.

Resolution FF

Not-for-Profit Hospital Pricing
KY Society of KOGS — KY Section of ACOG

WHEREAS, not-for-profit hospitals in the Commonwealth of Kentucky are tax exempt, and

WHEREAS, tax exempt corporations are tax exempt because they benefit the Commonwealth and the individual taxpayer without discrimination, and

WHEREAS, all taxpayers within the Commonwealth of Kentucky equally support not-for-profit hospitals, and

WHEREAS, since all taxpayers equally support nonprofit hospitals, none should be discriminated against on the basis of price, and

WHEREAS, many not-for-profit hospitals currently offer differentials in pricing for so-called provider arrangements thereby effectively discriminating against those taxpayers who utilize the hospital who are not enrolled in a particular PPO or HMO, and

WHEREAS, that is contrary to fair treatment of those taxpayers who are not members of PPOs with which the hospital contracts, now therefore be it

RESOLVED, that the Kentucky Medical Association petition the State Department of Insurance and the Kentucky State Legislature to prohibit not-for-profit hospitals in the discrimination of pricing of patients, regardless of class or type of insurance and that PPO arrangements for not-for-profit hospitals be prohibited without allowing the same price discount to all patients using the hospital facilities.

Recommendations, Reference Committee No. 3:

Reference Committee No. 3 reviewed Resolution FF, Not-for-Profit Hospital Pricing, introduced by the KY Society of KOGS — KY Section of ACOG, and recommends that the "Resolved" be changed as follows:

"**RESOLVED, that the Kentucky Medical Association petition the State Department of Insurance and the Kentucky State Legislature to prohibit not-for-profit hospitals [~~in the~~] *from* discrimination [~~of pricing~~] *in billing* of patients, regardless of class or type of insurance, and that PPO arrangements for not-for-profit hospitals be prohibited without allowing the same price discounts to all patients using the hospital facilities.**"

Reference Committee No. 3 recommends the adoption of Resolution FF as amended.

The motion was seconded from the floor and carried. Resolution FF, Adopted as amended, reads as follows:

WHEREAS, not-for-profit hospitals in the Commonwealth of Kentucky are tax exempt, and

WHEREAS, tax exempt corporations are tax exempt because they benefit the Commonwealth and the individual taxpayer without discrimination, and

WHEREAS, all taxpayers within the Commonwealth of Kentucky equally support not-for-profit hospitals, and

WHEREAS, since all taxpayers equally support nonprofit hospitals, none should be discriminated against on the basis of price, and

WHEREAS, many not-for-profit hospitals currently offer differentials in pricing for so-called provider arrangements thereby effectively discriminating against those taxpayers who utilize the hospital who are not enrolled in a particular PPO or HMO, and

WHEREAS, that is contrary to fair treatment of those taxpayers who are not members of PPOs with which the hospital contracts, now therefore be it

RESOLVED, that the Kentucky Medical Association

petition the State Department of Insurance and the Kentucky State Legislature to prohibit not-for-profit hospitals from discrimination in billing of patients, regardless of class or type of insurance, and that PPO arrangements for not-for-profit hospitals be prohibited without allowing the same price discount to all patients using the hospital facilities.

Resolution GG

Neurologically Impaired Newborns
KY Society of KOGS — KY Section of ACOG

WHEREAS, the problem of neurologically impaired newborns is an integral part of the professional liability problem in all states, and

WHEREAS, this is also true in the Commonwealth of Kentucky, and

WHEREAS, the statute of limitations related to minors and the catastrophic damages which may be claimed in neurologically impaired newborn suits exceed the limits of nearly all insurance policies, and

WHEREAS, the overall aim of civilization should be to provide for those who are unfortunate and need provision, and

WHEREAS, a cause of the neurologically impaired newborns' problems can rarely, if ever, be definitely identified, and

WHEREAS, regardless of fault, a neurologically impaired newborn requires great amounts of expenditures, care, and nurturing, and

WHEREAS, it is impossible in the current tort system to adequately evaluate these claims and in an unemotional way allow for appropriate and fair awards, and

WHEREAS, other states have implemented pilot projects of a no-fault type to provide for the care outside of the traditional tort system for neurologically impaired newborns, and

WHEREAS, this saves significant numbers of dollars in legal fees and affects only a very small number of plaintiffs or attorneys, but a significant amount of dollars expended in overall claims, now therefore be it

RESOLVED, that the Kentucky Medical Association develop and introduce legislatively a schedule of payments for neurologically impaired newborns of either a no-fault or a fault-based schedule of compensation to be introduced into the 1990 Legislature and lobby for its passage, and be it further

RESOLVED, that in the alternative, that a second pilot project be developed and introduced into the Legislature that would allow for binding arbitration to be signed prior to the institution or prenatal care which would effectively allow and enforce this type of arrangement.

Recommendations, Reference Committee No. 3:

Reference Committee No. 3 reviewed Resolution GG, Neurologically Impaired Newborns, introduced by the KY Society of KOGS — KY Section of ACOG, and recommends it be adopted.

Mr. Speaker, Reference Committee No. 3 recommends the adoption of the Report of Reference Committee No. 3 as a whole.

Mr. Speaker, I would like to thank the members of the Reference Committee who so ably assisted this House of Delegates in its review of these issues and its formulation of policy in these matters. Members of the Committee are Charles R. Dodds, MD, Earlington; David W. Kinnaird, MD, Louisville; E. C. Seeley, MD, Lexington; and Mary L. Wiss, MD, Pikeville. I also want to thank Ms. Doris Crume for her assistance to the Reference Committee in the preparation of this report.

REFERENCE COMMITTEE NO. 3

Paul R. Smith, MD, London, Chairman
Charles R. Dodds, MD, Earlington
David W. Kinnaird, MD, Louisville
E. C. Seeley, MD, Lexington
Mary L. Wiss, MD, Pikeville

Report of the Chairman, KEMPAC Board of Directors

Mr. Speaker, Fellow Delegates:

It is a pleasure for me as chairman of the KEMPAC Board of Directors, to give you a report of KEMPAC activities for this past year.

As a Board, appointed by the KMA Board of Trustees, we are permitted to support candidates that share our concerns in regard to legislation that affects the medical profession and *quality patient care*. We win friends during political campaigns by helping in many ways. When our *views* are made known to a candidate, along with *financial support* and *volunteer work* during their efforts to be elected, it is remembered after they take office.

We are pleased to tell you that because of your support, KEMPAC has contributed over $100,000.00 to candidates in the primary and general election this year. This money was given early in the primary and has already been given for the candidates in the general election. We were able to give substantial support to *key* legislative races.

At KEMPAC's request, AMPAC has contributed in excess of $30,000.00 to Kentucky candidates for the U.S. House.

I must emphasize that although KEMPAC-AMPAC funds are given in the name of Kentucky physicians, your individual support as a physician Candidate Support Committee member on the *local* level is very important, if not the most important factor. That personal contact is so very significant.

Let's go back a few moments to "A Dream," an article

that was published in the May issue of the *Journal of the Kentucky Medical Association*. Hopefully, you will remember that in "A Dream" I attempted to phase in 1988.

Phase One is now a reality. All KMA officers, delegates and alternate delegates to the AMA, and KMA Board of Trustee members, are sustaining KEMPAC-AMPAC members.

Phase Two is still a dream — that is, all KMA delegates for 1988 are KEMPAC members. That's you. I am asking you as the governing Board of the Kentucky Medical Association to give this most serious consideration. If you are not a member, you can join tomorrow at the KEMPAC booth located in the convention area. If you are a member, please recruit one of your fellows. Only you can make Phase Two a reality. I very much want all of you to proudly wear the 99-plus pin.

Phase Three — an increase in KEMPAC membership to 1,150 for 1988 is still 150 short. Our membership has increased 17% over last year, however.

In 1987, as in past years, the KMA House of Delegates reaffirmed its belief in the objectives of KEMPAC and AMPAC and recommended 100% participation by doctors in Kentucky. It further recommended a vote of endorsement and encouragement to the KEMPAC organization to continue its worthwhile political efforts on behalf of our free enterprise system and the freedom of the art and science of medicine.

I recommend that you reaffirm and include the billing of KEMPAC-AMPAC dues in the statewide billing of 1989 KMA dues. (The motion was seconded from the floor and carried.)

On behalf of the KEMPAC Board, I want to thank you delegates and the KMA Board of Trustees for your support.

Sam D. Weakley, MD

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 4

Ardis D. Hoven, MD, Lexington, Chairman

Reference Committee No. 4 considered the following Reports and Resolutions:

27. Report of the Committee on Medical Insurance and Prepayment Plans
28. Report of the Committee on Claims and Utilization Review
29. Report of the Peerview Oversight Committee
30. Report of the Committee to Investigate Changing Trends in Medicine

Resolution F — Hiring of Faculty for Private Practice (Jefferson County Medical Society)
Resolution R — Patient Advocacy and Third-Party Payors (Bell County Medical Society)
Resolution W — Support of Nursing Education (Board of Trustees)
Resolution Y — Minimum Requirements for Managed Health Care Systems (Board of Trustees)

ITEMS FOR CONSENT

Reference Committee No. 4 reviewed the following items and recommends they be filed by consent of the House without discussion.

27. Report of the Committee on Medical Insurance and Prepayment Plans — filed
28. Report of the Committee on Claims and Utilization Review — filed
29. Report of the Peerview Oversight Committee — filed

Mr. Speaker, Reference Committee No. 4 recommends adoption of the Consent Calendar as a whole.

Report of the Committee on Medical Insurance and Prepayment Plans

The Committee on Medical Insurance and Prepayment Plans met on December 9, 1987, and June 15, 1988.

KMA-Endorsed Group Health Insurance Plan

Much of the Committee's time continues to be devoted to monitoring, discussing, and developing options to our group health insurance plan to stabilize rates while assuring that comprehensive benefits are available to the membership.

In February, the rates for KMA's low option plan increased by 49% for the single coverage and 46.1% for family coverage. The high option rates increased by 40.2% for the single plan and 36.7% for family coverage.

A review of the utilization of the KMA group options showed that admissions per thousand members, average length of stay per thousand members, and cost per day, all exceeded statewide averages. This study of our utilization patterns also reflects, to some degree, the impact of high cost cases, including cardiovascular, psychiatric, and chemotherapy admissions. Our high option plan has utilization of inpatient services significantly above statewide averages. This indicates admissions for serious illness, such as circulatory system problems and mental disorders.

In 1986, the House approved a policy of allowing certain cost containment provisions to be added to our plan on a trial basis, with a report on the effectiveness of those measures made to the Board of Trustees and House, as appropriate. While authorized in 1986 for the enrollment period of February 1987 through January 1988, the cost containment

options were not used because rate increases were moderate. However, because of the utilization experience during that period, a cost containment program (Assurance Plus) was incorporated into the low option plan for the enrollment period that began in February of 1988.

Because of the lag time between the occurrence of claims and their submission and the fact that this report is written in mid-summer, only a few months after Assurance Plus went into effect, we are unable to determine what effect this option is having on utilization. We should have a clearer picture of its effect by the time we make recommendations to the Board in December regarding renewal of the plan in 1989.

The Committee is frustrated over the continuing premium increases in our plan. We discuss the plan, its cost, benefit structure, and plan administration every time we meet.

We've discussed using another carrier. We have not recommended that course of action. Changing to another carrier might bring about a slight decrease in premium the first year because a carrier might want to get the business and submit an attractive rate. According to the Kentucky Department of Insurance, there is usually about a three-month period between the time enrollees begin paying premiums and claims begin coming to the carrier, so there is a period of sizeable income with relatively little expense.

After a year of experience, utilization patterns begin to emerge, and in all probability, rates would increase substantially. In addition, carriers will often require the purchase of life insurance in order to buy health coverage, which in the long term could be more expensive.

Another consideration is the lack of enthusiasm on the part of other carriers to underwrite a statewide group. It is much easier and less expensive to deal with a large group of employees in one or two locations than it is to administer a plan with enrollees spread all across the state.

KMA's plan costs are high because utilization of the plan is high. We continually monitor our utilization and in almost every category, our utilization rates are higher than the statewide average. Summaries of that utilization have been presented to the House in the past and have not changed markedly from year to year.

We are considering some options for the 1989 renewal. We could begin an age bracket underwriting program. This would mean that older participants would pay more and younger ones would pay less, since utilization by older participants is usually higher.

We are considering a requirement of medically underwriting groups of two to nine participants. We could offer a higher deductible. There is a possibility of offering the Blue Cross and Blue Shield Option 2000 plan, but it is not available everywhere in Kentucky and would exclude hospitalization at some hospitals.

Blue Cross and Blue Shield reports that costs are continuing to increase in all its business. While hospital census is decreasing, rates are going up 6% to 7% on the average. A combination of increased physicians' fees and individual charges for services (unbundling) are generating increases in the physician component of approximately 18%. These increases are reflected in KMA's group experience.

Meeting with Insurance Commissioner

Substitute Resolution J, Managed Care Systems, was adopted by the House in 1987. Substitute Resolution J directed KMA to petition the Commissioner of Insurance to initiate regulations, legislation, or whatever means available to eliminate the confusion created by health insurors. It was felt this might be accomplished by imposing appropriate rules and regulations to overcome problems incurred with managed care plans.

Your Chairman attended a meeting held with Insurance Commissioner Morgan and Officers of KMA in early June. The Chairman of KMA's Trends Committee also was in attendance, as was the Department's Legal Counsel, Director of the Life and Health Division, and three compliance officers. Our reception was cordial, and the Commissioner and his staff were sympathetic to our concerns.

Mr. Morgan and his staff shared some of the difficulties they face in licensing and compliance and pointed out that much of their statutory authority deals with assuring that plans are solvent and in compliance with reserve requirements, and whether or not requests for rate increases are reasonable and necessary.

A concern common to KMA and the Department is the apparent lack of awareness on the part of insureds over various restrictions in managed care plans. People may read explanations of benefits, but not really understand them. More likely, however, is an apathy about covered benefits until they are needed. The 1988 Kentucky General Assembly enacted legislation requiring insurance carriers to develop benefit explanations directed to a "lay" audience, and the Commissioner felt that might be helpful.

As a result of our meeting at the Commissioner's office, officials representing the Insurance Commissioner's office met with the Insurance Committee in June. Areas discussed included definition and description of medical necessity; definitions and determination of usual, customary, and reasonable charges; and the financial status of managed care programs.

The Committee felt these two meetings opened lines of communication and increased the understanding and awareness of mutual concerns. We plan to continue our dialogue with the Commissioner's Office and to address the problems outlined in Substitute Resolution J.

Psychiatrists' Concerns

The Committee received correspondence from the medical staff of a large psychiatric facility in Louisville.

The medical staff was concerned with preadmission review requirements for elective psychiatric admissions and

with one hospital-owned carrier's interference in the practice of psychiatry. Preadmission certification is now widely required for all elective psychiatric admissions.

While no action was asked of the Committee, we felt it appropriate to begin working toward the development of guidelines to protect the patient's confidentiality during the preadmission process.

Managed Care System

The Trends Committee report carries a detailed look at managed care programs in Kentucky. The number of HMOs, the type of managed care program most common in Kentucky, once numbered 13. Because of mergers or failures, there are now nine HMOs. According to the Department of Insurance, total losses reported in 1987 were $25,940,659. However, enrollment in managed care systems continues to grow.

The business community has taken serious interest in alternate plans as a way to deal with increasing premiums. However, in spite of the growth of managed care plans, there appears to be disillusionment with them since their costs are often not significantly lower than traditional coverage.

Whether or not this enrollment growth will continue remains to be seen. What is of great concern is the possibility that the emphasis put on competition as the means of stabilizing health costs will be replaced with a renewed focus on regulation, or even some type of nationalized delivery mechanism with physicians as the primary target.

Your Committee members have worked hard on your behalf this year, and as Chairman, I appreciate their continuing interest, participation, and contribution to our deliberations.

Earl P. Oliver, MD
Chairman

Report of the Committee on Claims and Utilization Review

The Claims and Utilization Review Committee has not been as active as in previous years because of a decrease in claims submitted. The volume of claims reviewed at the district level has likewise diminished; although, the level of activity is greater than that which occurs at the state level.

Most all medical procedures recognized and reimbursed by insurance carriers are well profiled, so few questions arise relating to charges. Likewise, quality of care is seldom at issue, and as the insurance market becomes increasingly competitive and costs are contained through administrative procedures, medical questions seldom arise.

The Committee has, however, noted two trends which are of some concern. The first is, while the forces of competition have reduced the number of medical questions, this may be an indication that a full spectrum of care is not always provided or perhaps not always covered in every situation. Obviously, this works to the detriment of the patient. The Committee strongly approves of internal medical review conducted by insurance companies, so long as practicing physicians serve as reviewers. It is an unfortunate assumption that this may not always be the case and review is a simple bookkeeping process.

A second concern the Committee has observed is that as more and more restrictions are placed on covered benefits and methods of delivery, and as administrative procedures required by physicians are increased, there seems to be an increase in the number of services provided. Perhaps the increase of services is a reaction to restriction of noncovered benefits. Regardless of strictures placed on physicians, it is hoped that, as always, the physician's concern for his patient's welfare will ensure that quality of care remains the highest priority.

In view of the market forces at bear that have reduced review activity, the committee intends, in the coming year, to expand its efforts to increase physician review in ways that will best benefit the profession and patient.

As Chairman, I would like to thank all of the Committee members for their considerable help and input this year. On behalf of the entire membership, I would like to thank the chairmen and members of the district review committee for their diligent efforts.

K. Thomas Reichard, MD
Chairman

Report of the Peerview Oversight Committee

The Peerview Committee has not met often, due to scheduling difficulties and preemption by legislative activities. However, the work of the Committee is felt to be important to the Association's mission, as well as to individual physicians who are subject to the influence of the professional review organization's operations.

Numerous letters were received protesting various operations of Peerview, the PRO for Kentucky. Most of these letters related to situations of individual claim denials, and the universal problems appeared to be the unavailability of reviewers to the attending physician and the general lack of responsiveness by Peerview. Specific issues involved communications problems and Peerview operational procedures. It might well be that some of the unresponsiveness was due to the fact that Peerview Headquarters is located out-of-state, and the in-state office was not appropriately organized from the standpoint of personnel and resources.

Regardless of the reasons, many physicians experienced a great deal of difficulty in trying to discuss claims questions or denied claims with a physician reviewer. It should be noted

that the medical director of Peerview was not unresponsive to the Committee. In recent months, this general lack of responsiveness has improved.

Currently, the Peerview contract is coming to a close, and a new contract phase has been instituted. Unconfirmed information indicates that a number of organizations will bid to acquire the PRO contract for Kentucky. Included in these bids is Peerview, which apparently has established a corporation in Kentucky. Representatives from the former PRO, the Kentucky Peer Review Organization, have expressed interest in acquiring the PRO contract. It has also been learned that as many as five other organizations may be involved in bidding. The Board of Trustees has taken the position that it will not endorse any organization for the PRO contract because the PRO requirements will likely become even more onerous to physicians than they currently are.

In addition to the importance of the PRO bidding situation, its outcome has even further significance. Because of the federal matching funds formula for the Medicaid Program, whatever organization is selected as the PRO will probably also become the reviewer for the Kentucky Medicaid Program. While Medicaid imposes different review requirements than Medicare does, the general influence of the PRO becomes fairly widespread.

In the coming year, the Committee intends to more vigorously pursue three areas. The first is to monitor the bidding process and establish communications with whatever organization is selected. Second, the Committee hopes to serve as an advocate on behalf of physicians with individual problems relating to claims reviewed by the PRO. Finally, the Committee hopes to monitor PRO operations at all levels and be prepared to represent the views of Kentucky physicians to the appropriate federal administrative agencies, as well as to Kentucky's Congressional delegation. The Committee would welcome input from interested members.

James M. Bowles, MD
Co-Chairman
Richard S. Miles, MD
Co-Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Committee to Investigate Changing Trends in Medicine

The KMA Committee to Investigate Changing Trends in Medicine was appointed to study and recommend policy positions on issues confronting medicine. Because of KMA's legislative activities this year, the Committee was able to meet only once, but considered an issue of extreme importance to all physicians in Kentucky, the current nursing shortage.

There are 1.9 million Registered Nurses in the United States and 750,000 Licensed Practical Nurses. About 1.5 million RNs are in the work force either part-time or full-time, and about 68% are employed in hospitals, according to the AMA. It is estimated there are at least 100,000 certified nurse practitioners and clinical nurse specialists in the United States, but this is difficult to confirm due mainly to problems of definition. In hospitals, 71% of the nursing force is represented by technical nurses with the associate degree/diploma preparation. In nursing homes, LPNs outnumber RNs 4 to 1.

Presently there are four levels of nursing education, the twelve-month Licensed Practical Nurse (LPN), the two-year Associate Degree Nurse (ADN), the three-year hospital-based or diploma nurse (Diploma), and the four-year baccalaureate nurse program.

Registration to practice nursing can be obtained through the same Board examination taken by the ADN, Diploma, and four-year baccalaureate nurse. License to practice as an LPN is acquired through a special examination. According to the AMA, all licensure examinations are produced and monitored through the National Council of State Licensing Boards. All programs in nursing education are accredited through the National League for Nursing. The American Nurses Association certifies about 45% of the clinical nurse specialists and nurse practitioners; otherwise, ANA is not directly involved with education.

Nursing shortages appear to be cyclical in nature and have been a problem for the United States on and off since after the first World War. After World War II, the shortage of medical and nursing personnel became critical. Community colleges emerged to promote easy access to education at a low cost. The National League for Nursing Education recommended, through the Association of Junior Colleges, that a study be made of the feasibility of incorporating nursing education into their programs, and in 1952, the two post high school associate degree programs began. At about the same time, twelve-month programs started during World War II for Licensed Practical Nurses were incorporated into some, but not all, junior colleges.

In the middle sixties, the American Nurses Association stated that all nursing programs should be within the general education system. Diploma or hospital-based programs were considered unproductive to the independence required by any profession to govern its own educational concerns. In 1966, ANA established a position which supported two levels of entry into nursing practice: the technical nurse with an associate degree, and a professional nurse with a BSN or four-year degree. Hospital-based programs and LPNs were to be phased out, and the ANA recommended the systematic replacement of LPN and Diploma programs with associate degree education.

Originally, the associate degree was viewed as an interim step to the baccalaureate program. It became clear, however, toward the end of the 1970s, that only 3% of the graduates from ADN programs, and less than 10% of the Diploma

graduates, continued their formal education to BSN status.

During this time, the American Medical Association and the American Hospital Association continued to view all levels of nursing education as appropriate, and during the late 1960s, reaffirmed support for nursing programs at all levels, including higher education for leaders and teachers in nursing. That position was reaffirmed in July of 1980. However, at that same time, recruitment into all nursing programs had declined 2%, and a shortage of nurses giving direct patient care was recognized by organized medicine as urgent.

Organized medicine has and continues to support increasing educational opportunities for nurses in order to enhance their capabilities at the bedside. There is evidence, however, indicating that increasing the level of education also provides options that remove nurses from the bedside.

Originally, advanced education for nurses was intended to promote leaders, managers, and public health nurses for community services. BSN programs accentuate health maintenance, wellness, and leadership skills, as well as traditional nursing skills. As patient services in hospitals became more complex and technical, the clinical nurse specialist, with a Masters Degree, was developed to fill the need for complex clinical care at the bedside.

Approximately 29,000 nurses are licensed in Kentucky and about 26,000 are currently employed. It is estimated that only 500 are working in nonpatient care settings. Yet, most hospitals and nursing homes are reporting nursing vacancies.

The causes of this shortage are not simple and did not occur overnight. In the interest of cost containment, staffing has been cut to barest minimums. The patients now hospitalized are sicker when admitted and require more, not less, in-house care. They are an older population as well and limited in their ability to provide self care. Met with medical staff complaints, the feeling of being unable to meet patients' needs, and pressure from hospital administrators, nurses are experiencing unprecedented stress in their work place. This is driving many of our most dedicated and best trained nurses out of the hospital and into physicians' offices, home health care agencies, insurance companies, and industry, as well as to drug companies. The practice of using RNs on a part-time, p.r.n. basis with no benefits package, shift hours, or holiday hours, and a pay-scale generally lower than jobs for persons with comparable education, have added to the stress-burnout syndrome. These must be considered the major contributing factors. Hardest hit have been the critical care areas. Larger hospitals with larger salaries, flexible hours, bonuses, and bounties for recruiters are luring nurses from smaller hospitals. These vacancies are difficult to fill. It cannot be denied as well that the real or perceived chance of exposure to the AIDS virus and the moral dilemma felt by health care personnel in general concerning care of these unfortunate patients is an issue. We as physicians cannot consider ourselves as removed from this crisis.

Treatment of our fellow nursing professionals is too often unprofessional. This complaint is as common as those concerning pay and benefits. They call us for questions or orders and are often treated rudely, with anger and, all too often, profanity. If indeed by 1990, as is predicted, there is a 300,000-plus national shortage of qualified nurses, what will happen to our patients, our practice, our hospitals?

The saddest commentary of all is that our good nursing school candidates are going into other fields. Quality of applicants is down on the average. Many qualified applicants are applying for and being accepted into medical schools. Some colleges are actively recruiting nursing students, just as some hospitals are hiring full-time nurse recruiters.

Several groups are trying to address the nursing shortage issue. The Kentucky Nurses Association, the Kentucky Hospital Association, and the Kentucky Association of Health Care Facilities all have committees addressing the problem. KMA supported a KNA request that Governor Wilkinson appoint a multi-interest task force to develop recommendations to solve the shortage problem, and the Governor has taken that request under advisement.

The AMA Board of Trustees, in responding to a mandate of the AMA House of Delegates to develop recommendations regarding the shortage, has suggested the establishment of a new non-nurse, bedside technician, to be called a Registered Care Technologist. The purpose of this plan is to provide a supply of technically oriented bedside caregivers who will improve patient access to needed medical care in hospitals.

The RCT's scope of practice would be to continuously monitor and implement physicians' orders at the bedside in order to support and promote the welfare of patients in institutions. There would be three levels of competence included in the program: assistant, basic, and advanced. The assistant to the RCT would function as a bedside aide equal to assistants now required by federal law for long-term facilities.

The basic RCT would subsidize work now performed at the level of Licensed Practical Nurses. Licensure as an RCT would be available to LPNs who desire to monitor and implement bedside medical care and administer routine, nonintravenous medications with supervision. Advanced RCTs would require an additional nine months of experience in several hospital intensive care units.

This proposal received considerable discussion during the AMA House of Delegates' meeting in June. Testimony in the Reference Committee went on for almost three hours on this single issue. While the AMA House of Delegates adopted the Board's report and referred the report back to the Board for action, it was clear that discussions with nurses' organizations will continue and that any activities to develop the RCT concept will be undertaken with caution on a limited pilot program basis. The RCT concept remains controversial, but has served to focus debate on one potential solution.

How can we, as Kentucky physicians, be part of the solution instead of part of the problem? Certainly, the dialogue with these health care task forces will help assess the problems and their causes, and hopefully find some solutions. These

won't occur overnight. Legislators may also need to address this crisis.

In the meantime, we should treat our nursing staff as fellow professionals and urge hospital administrators to reevaluate their pay and benefits packages. We should encourage the bright young "candy-striper" to consider nursing as a career. The situation will get better because it must. In an age of technology and medical care never before imagined, surely our patients must not suffer because of lack of nursing care. "High tech" and "high touch" must work together for our patients and our health care system.

The Trends Committee intends to continue to monitor Kentucky's nursing shortage and make recommendations to the Board and House as indicated.

AMA Survey of Physician and Public Opinion on Health Care Issues, 1988

In the past we have shared information gained from surveys of physicians and the public to determine their views on health care issues. Earlier this year, the AMA surveyed 1,000 physicians and 1,500 nonphysicians.

Physicians said the main problem facing medicine is cost. The item cited second most often was government regulation, followed by professional liability insurance. Eighty-one percent of the MDs surveyed said that the current efforts to control cost are hurting the quality of medical care. Nonphysicians agree that the cost of care is clearly perceived as the number one health-related problem by the majority of American adults.

Regarding the supply of physicians, 51% of the MDs said they felt the number of physicians in their community was about right; 36% said there were too many physicians; and 9% said there were too few. Sixty-one percent of the public said the number was about right; 10% said there were too many physicians; and 19% said too few.

An effort was made to determine the impact on physicians' practices of managed care systems and the perception of loss of control over the care of the patient. Physicians reported that Medicare, Blue Cross and Blue Shield, and commercial insurance comprised the majority of their patient base, with managed-care patients totaling about 14% of all patients. One-third of the physicians responding said the control over patients had remained the same; 6% said it had increased; and 51% said they had lost control over the care of the patient.

As an increasing number of physicians accept salaried positions, an emerging issue is the appropriate role of physicians in labor negotiations. Seventy-four percent of the MDs surveyed by the AMA support collective bargaining for physicians with employers over wages, hours, and working conditions. The survey noted younger physicians, and those in employer/employee relationships, were more likely to support the concept of collective bargaining; whereas, older physicians were less likely to support that concept.

The following question was posed to the nonphysician respondents. In 1986, the overall cost of health care in the United States averaged about $1800 per person. Given your opinion of the quality and availability of health care, do you think we get our money's worth for our spending on health care or not?

Sixty-four percent said they felt the quality of health care in the U.S. did not justify the overall cost. As this was clarified, it became clearer that the major problem is not the quality of care individuals receive, but what it costs. Most (42%) blamed insurance companies as the biggest source of recent increases in the cost of care.

The public's perception of the image of the physician is an ongoing interest of the AMA. Seventy-five percent of the nonphysicians surveyed indicated they felt their last MD visit was favorable. Of the 25% who indicated they had a problem with their last visit, *waiting time* was the most common complaint, followed by an *unsatisfactory personal interaction, time with the doctor,* and *cost.*

Thus, even though the public is really concerned about the cost of care and has some general feelings that physicians' fees are too high, their own personal physician encounters appear to be satisfactory.

Managed Care Systems in Kentucky

Enrollment in managed care systems continues to grow in Kentucky. Enrollment figures increased from 396,942 as of December 31, 1986, to 523,672 for the quarter ending December 31, 1987. As of March 31, 1988, (the latest figures available from the Department of Insurance) enrollment totalled 542,179. The number of managed care plans active in Kentucky decreased from 13 at the end of 1986, to 9 in June of 1988. Humana acquired MaxiCare in early 1988, giving it a combined enrollment of over 245,000.

Managed care plans in Kentucky continue to report significant financial losses, with only two companies indicating a profit. The total net loss reported to the Kentucky Department of Insurance for 1987 was $25,940,659.

It might be logical to believe that losses of this magnitude would stimulate carriers to try a different approach to reach their true goal, which is not to manage care, but to increase profits. That is not the case, however. Because of the significant investments carriers have made in these programs, insurance companies are increasing pressure on companies to discontinue the traditional free choice coverages which reimburse employees for most of their health costs and give them total control over selecting a doctor.

According to the *Wall Street Journal*, carriers are presenting premium increases of 25% or more for free choice plans, and in some instances, are refusing to offer such plans at any price. Instead, they offer their own HMO which is more restrictive but less expensive. The result is that free choice plans nationally have fallen to 44% of insuror's commercial

business in 1987, from 96% in 1984. We expect to see continuing growth of managed care plans and the development of more stringent provider cost controls.

In health care issues, any discussion of cost control immediately raises questions about the impact on quality. Quality is a subjective and illusive concept which people have been trying to quantify for some time. Physicians have been at the forefront of this movement for years through peer review activities of various descriptions.

The quality concept is becoming even more important because as costs are contained and quality questions arise, there will be differences of opinion as to quality depending upon where one stands economically and philosophically. The carrier wants maximum quality at the minimum price, which may not always be possible. Is it reasonable to believe the carrier would settle for minimum quality at the minimum price?

But how do we even know what quality is, much less what the extremes are? How do we measure it, and how do we know which measurements are realistic?

Insurance companies have their own data bases built over the years and will use that data to show that quality care is being delivered in their plans. Physicians do not. While at the leading edge of the development of peer review and quality assurance, the profession does not have a central repository of data that is an indicator of quality from the patient's and physician's point of view.

We may say that our hospital and medical society review committees have done a good job over the years and that physicians are really the only people qualified to review other physicians, and that is true. But a growing reliance on computerized contracted review, where the incentives are to rationalize cost containment, not quality assurance, does not bode well for physicians or our patients.

If quality is a worthy goal, physicians must determine what the standards of quality care are and have a basis for those standards. We are far from that at the moment.

Substitute Resolution J (1987)

Substitute Resolution J was adopted by the House of Delegates last year. It addressed several problems with managed care plans and called for KMA to petition the Kentucky Commissioner of Insurance to enact appropriate measures to correct those problems.

A meeting was held on June 1, 1988, between Insurance Commissioner Morgan and his top aides and the KMA Quick Action Committee. Earl P. Oliver, MD, Chairman of KMA's Committee on Insurance and Prepayment Plans, and I also attended. Our reception was cordial and opened lines of communication between KMA and the Insurance Department. Efforts are being made to deal with the issues raised in Substitute Resolution J and with others identified by the Commissioner.

As Chairman, I appreciate the effort and dedication of the Committee members this year.

Nelson B. Rue, MD
Chairman

Recommendations, Reference Committee No. 4:

Reference Committee No. 4 would like to commend the Committee to Investigate Changing Trends in Medicine on its excellent and exhaustive efforts on issues presented in its report. The Reference Committee recommends that Report No. 30 be filed.

Resolution F

Hiring of Faculty for Private Practice
Jefferson County Medical Society

WHEREAS, it has been reported that some newly hired faculty at the University of Louisville School of Medicine are to spend a high percentage of their time in private practice, and

WHEREAS, the University of Louisville is apparently preparing to create a faculty category primarily for the provision of services, as opposed to teaching and research, and

WHEREAS, if such reports are true, such activities would tend to call into question the basic purposes of medical school faculty and public funding thereof, now therefore be it

RESOLVED, that the Kentucky Medical Association encourage the Legislative Review Commission, the State Attorney General, the State Council on Higher Education, or other appropriate body to investigate the activities of newly hired faculty as they relate to public funding of higher education and the quality and purposes of medical education faculty, and be it further

RESOLVED, that the KMA encourage these same authorities to consider seriously whether a category of medical school faculty specifically to provide service, rather than the traditional role of teaching, research, and service, is in the best interests of the Commonwealth.

Recommendations, Reference Committee No. 4:

Reference Committee No. 4 next considered Resolution F, Hiring of Faculty for Private Practice, submitted by the Jefferson County Medical Society. A member of the Board of Trustees offered alternative wording to this Resolution, and Reference Committee No. 4 offers the following substitute Resolution:

"WHEREAS, it has been reported that some faculty physicians at the University of Louisville are being recruited and hired primarily to provide medical services to patients

in an effort to generate income instead of teaching medical students and house staff, and

"WHEREAS, while contractual arrangements are unclear, they are being widely interpreted as placing the medical school physician faculty in competition with the private sector while being subsidized by public funds, now therefore be it

"RESOLVED, that the Kentucky Medical Association continue its support of the traditional teaching mission of Kentucky's medical schools, and be it further

"RESOLVED, that it *is* appropriate to the teaching mission of the medical school for physician faculty members to provide teaching and research services while their income is being subsidized by public funding, and be it further

"RESOLVED, that the Kentucky Medical Association encourage the appropriate governmental agencies to investigate and report on the activities of medical school faculty members and their role in fulfilling the educational mission of medical schools in Kentucky."

Reference Committee No. 4 recommends adoption of the Reference Committee's substitute Resolution in lieu of Resolution F.

The motion was seconded from the floor. William B. Monnig, MD, Chairman of the Board of Trustees, made a motion to amend the proposed substitute Resolution in the final Resolved by replacing the words **"encourage the appropriate governmental agencies,"** with **"ask the KMA Board of Trustees . . ."** The motion was seconded and carried.

Substitute Resolution F, adopted as amended, reads as follows:

Substitute Resolution F

WHEREAS, it has been reported that some faculty members at the University of Louisville are being recruited and hired primarily to provide medical services to patients in an effort to generate income instead of teaching medical students and house staff, and

WHEREAS, while contractual arrangements are unclear, they are being widely interpreted as placing the medical school physician faculty in competition with the private sector while being subsidized by public funds, now therefore be it

RESOLVED, that the Kentucky Medical Association continue its support of the traditional teaching mission of Kentucky's medical schools, and be it further

RESOLVED, that it is appropriate to the teaching mission of the medical school for physician faculty members to provide teaching and research services while their income is being subsidized by public funding, and be it further

RESOLVED, that the Kentucky Medical Association ask the Board of Trustees to investigate and report on the activities of medical school faculty members and their role in fulfilling the educational mission of medical schools in Kentucky.

Resolution R

Patient Advocacy and Third-Party Payors
Bell County Medical Society

WHEREAS, it is in the best interest of both patient and physician to promote and sustain the confidentiality of the traditional patient-physician relationship, for reasons of therapeusis, hodegetics, economics, and liability considerations, and

WHEREAS, a contractual relationship is thereby established between the patient and the physician, and

WHEREAS, the Law of Contract is specific to the two parties involved and is protected by provisions of the U.S. Constitution, and

WHEREAS, it has become the practice of some third-party health insurance companies to require the patient subscriber's physician to contact said third-party health insurance company as a condition of fulfilling the insurance contract with the patient, and

WHEREAS, no two contracting parties can agree on the involuntary participation of a third party, and

WHEREAS, the relationship between a patient and his health insurance company with whom he has a financial contract, either of his own arrangement or through an employer acting as his agent, is one between two such contracting parties, and

WHEREAS, a physician who is not a party to said contract between a patient and his health insurance carrier cannot be legally obligated by it, and

WHEREAS, it has become the practice of other third-party health insurance companies to establish the role of "Patient Advocate" through the provision to the patient of a communication to present to the provider requesting reasonable pertinent information for the patient to provide to the insurance company to facilitate the provision of financial coverage, and

WHEREAS, thereafter it is an agent of the insurance company who initiates contact with the physician, or the hospital administration, or both, as the need may be, acting on behalf of the patient; ie, as the patient's advocate, and

WHEREAS, this is of considerable economic relief to both the patient's physician and the patient's hospital, and for this reason is much to be desired by them, and

WHEREAS, a great many physicians do not have and do not wish a contractual relationship with the patient's insurance company, now therefore be it

RESOLVED, that the Bell County Medical Society and the Kentucky Medical Association approve and promote the concept and adoption by third-party insurance companies of the use of the "Patient Advocate," who is an agent employed by a third-party insurance company to act on behalf of an insured patient in contacting a providing physician or hospital, in the event further reasonable information is desired by the insurance company from providers (to facilitate provision of

financial coverage of a patient subscriber), than what is initially provided to the patient by the physician, on an explanatory form the company provides to the patient for the purpose, and be it further

RESOLVED, that the Bell County Medical Society and the Kentucky Medical Association undertake actively to educate and exhort both patients and third-party payors to utilize the patient advocacy mechanism and allow appropriate responsibility for self-care to be exercised by the patient.

Recommendations, Reference Committee No. 4:

Reference Committee No. 4 next considered Resolution R, Patient Advocacy and Third-Party Payors, submitted by the Bell County Medical Society, and recommends that it be referred to the Board of Trustees.

Resolution W

Support of Nursing Education
KMA Board of Trustees

WHEREAS, the Kentucky Medical Association recognizes and is concerned about the shortage of bedside nurses in Kentucky and has asked the Committee to Investigate Changing Trends in Medicine to work with other interested groups to find a solution, and

WHEREAS, KMA representatives serve on task forces of the Kentucky Nurses Association and the Kentucky Hospital Association studying this issue, and

WHEREAS, the Kentucky Medical Association supports the Kentucky Nurses Association in its request that Governor Wilkinson appoint a task force to address this issue, and

WHEREAS, the Kentucky Medical Association views all levels of nursing education as appropriate, including higher education for leaders and teachers in nursing, and

WHEREAS, the Kentucky Medical Association has and continues to support increasing educational opportunities for nurses in order to enhance their capabilities at the bedside, and

WHEREAS, the Kentucky Medical Association is aware of the pilot program of the American Medical Association to study the feasibility of a new, non-nurse, bedside technician, to be called a Registered Care Technologist, and

WHEREAS, the purpose of such a pilot study is to test the feasibility of training a supply of technically oriented caregivers who will improve patient access to needed medical care in hospitals but is not intended to, in any way, replace Registered or Licensed Practical Nurses, now therefore be it

RESOLVED, that the Kentucky Medical Association recognize that the Registered Care Technologist pilot study is one of many possible ways to deal with the current shortage of bedside nurses, and be it further

RESOLVED, that the Kentucky Medical Association take no position for or against the concept of the Registered Care Technologist until the results of this pilot study are available, and be it further

RESOLVED, that quality care of the patient remain the primary focus of the Kentucky Medical Association in any activities undertaken to address the current shortage of bedside nurses, and be it further

RESOLVED, that the Kentucky Medical Association reemphasize its support for the necessary improved conditions to attract and maintain an adequate supply of nurses to assure the continued availability of quality medical care, and be it further

RESOLVED, that the Kentucky Medical Association continue to emphasize the importance of good professional relationships between physicians and nurses.

Recommendations, Reference Committee No. 4:

Reference Committee No. 4 next considered Resolution W, Support of Nursing Education, submitted by the Board of Trustees. The Committee was fortunate to hear testimony from Betty M. Porter, EdD, RN, President, Kentucky Nurses Association, in reference to the nursing shortage and needs in the state of Kentucky. Her comments were appreciated and continued communication between the KMA and other concerned organizations in dealing with this significant issue is encouraged. Reference Committee No. 4 recommends adoption of Resolution W.

Resolution Y

Minimum Requirements for Managed Health Care Systems
KMA Board of Trustees

WHEREAS, managed care is a concept growing in popularity among purchasers of health care in the United States, and

WHEREAS, most plans are purchased by management or negotiated by union leaders, and

WHEREAS, many employees are often apathetic about health care plans or do not understand restrictions of the plans until they become ill, and

WHEREAS, patients may find that they must be hospitalized in locations away from the community in which they live, not because appropriate hospital and physician services are not available in their community, but because the attending physician or community hospital does not participate in the patient's health plan, and

WHEREAS, this situation puts an unnecessary burden on the patient and the family in a time of stress and is not in the best interest of the patient or the patient's family, now therefore be it

RESOLVED, that the Kentucky Medical Association develop guidelines identifying those minimum patient coverages the medical profession feels any managed care plan or other insurance plan should have, as well as those requirements felt to be unnecessary and not in the best interest of the patient, and be it further

RESOLVED, that consideration be given to a means by

which these minimum standards could be developed, and be it further

RESOLVED, that once minimum standards are developed and approved by the KMA Board of Trustees and/or House of Delegates, they be given wide distribution to the news media, managed care systems, and other appropriate agencies and individuals.

Recommendations, Reference Committee No. 4:

Reference Committee No. 4 next considered Resolution Y, Minimum Requirements for Managed Health Care Systems, submitted by the Board of Trustees. The Committee encourages the KMA to continue to monitor the activities of managed health care systems in the best interests of our patients. Reference Committee No. 4 recommends the adoption of Resolution Y.

Mr. Speaker, Reference Committee No. 4 recommends the adoption of the Report of Reference Committee No. 4 as a whole, as amended.

I would sincerely like to thank the other members of the Committee: James M. Bowles, MD, Madisonville; Donald E. Brown, MD, Somerset; Frank K. Sewell, MD, Henderson; and Larry J. Wilson, MD, Louisville, for their work. I would also like to thank Martha Coombs for her assistance in the preparation of this Report.

REFERENCE COMMITTEE NO. 4

Ardis D. Hoven, MD, Lexington, Chairman
James M. Bowles, MD, Madisonville
Donald E. Brown, MD, Somerset
Frank K. Sewell, MD, Henderson
Larry J. Wilson, MD, Louisville

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 5

Scott B. Scutchfield, MD, Danville, Chairman

Reference Committee No. 5 considered the following Reports and Resolutions:

31. Report of the Committee on Maternal and Child Health
32. Report of the Technical Advisory Committee on Physician Services (Title XIX)
33. Report of the Committee on Community and Rural Health
34. Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports
35. Report of the Advisory Committee to CHR
5. Report of the Chairman, Board of Trustees, Special Report A — Physician Voluntary Medicare Assignment Program, **only**

Resolution B — Tobacco-Free Schools (Fayette County Medical Society)
Resolution C — Child Car Seat Safety (Fayette County Medical Society)
Resolution G — Out-of-State School Physical Examination Requirements (Jefferson County Medical Society)
Resolution H — Enforcement of Laboratory Regulations (Jefferson County Medical Society)
Resolution I — Voluntary Medicare Assignment (Jefferson County Medical Society)
Resolution O — DRGs (Fayette County Medical Society)
Resolution Q — Patient Copayments for Hospitalized Medicare Patients (Bell County Medical Society)
Resolution S — Childhood Immunizations (Jefferson County Medical Society)
Resolution V — Disposal of Medical Waste (Board of Trustees)
Resolution AA — Patient Counseling (Board of Trustees)
Resolution BB — Health Department Ambulatory Care Program (Board of Trustees)
Resolution CC — Weekend Transfer from Hospital to Nursing Home (Warren County Medical Society)

ITEMS FOR CONSENT

Reference Committee No. 5 reviewed the following items and recommends they be filed as indicated, by the consent of the House, without discussion:

32. Report of the Technical Advisory Committee on Physician Services (Title XIX) — filed
33. Report of the Committee on Community and Rural Health — filed
34. Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports — filed
35. Report of the Advisory Committee to CHR — filed

Mr. Speaker, Reference Committee No. 5 recommends adoption of the Consent Calendar as a whole.

Report of the Technical Advisory Committee on Physician Services (Title XIX)

The KMA Technical Advisory Committee on Physician Services to the Title XIX Program dealt with a number of issues this year on behalf of the membership.

Of major concern was an announcement in late June by the Secretary of the Cabinet for Human Resources that a $35.8 million deficit was predicted for the Medicaid Program. The deficit was caused by reduced State revenues and by Federal catastrophic care legislation and other changes to the

Medicare law, which required Federally mandated Medicaid coverage. The deficit was resolved by revising the internal CHR budget. This provided $28.2 million when related to the Federal matching funds.

A total of $7.6 million of the deficit was resolved by reduction of Medicaid reimbursements. The major reimbursement reductions were in the areas of hospital out-patient services, where reimbursement was reduced from 70% to 65% of charges, and in payments to ambulatory surgical centers, where a reduction from 100% to 65% of charges was made.

Another issue related to the inclusion of nonsteroidal, anti-inflammatory drugs on the Medicaid Formulary. Earlier in the year, all such drugs were removed from the Formulary in the interest of cost. A number of outside parties made significant attempts to have the drugs replaced on the Formulary and, finally, were successful in having a bill introduced which would have placed this single category of drugs back on the Medicaid list. During the legislative process, the Governor added these drugs to the Formulary by Executive Order, which was an appropriate move.

Ideally, all drugs should be on the Formulary, but the effect on costs to the Medicaid Program of such an action would be disastrous. By placing the drugs on the list by Executive Order, the Governor established the precedent of changing a single, line item Formulary product by law. The corollary to this action is that, at the urging of the Secretary of CHR, KMA requested that physicians use these drugs judiciously to prevent overspending of Formulary monies.

During the year, the TAC had studied the addition of physician office laboratory tests for payment by the Medicaid Program. After some review, as well as analysis by an Independent Laboratory Ad Hoc Advisory Committee, two new tests were added for reimbursement. These were potassium and cholesterol level testing, and blood and bone marrow studies performed by hematologists and oncologists. These tests were adopted by the Department for Medicaid Services and will be reimbursed to physicians when performed in their offices.

The Committee observed with some concern other activities of this Independent Laboratory Ad Hoc Advisory Committee. As an Advisory Committee to the Department of Medicaid Services, the group's efforts were benign and positive. However, using this group as a forum, some individuals pursued other directions. The result was that a bill was proposed in the Legislature which would have required all physicians' offices which performed *any* laboratory services to meet the State's clinical laboratory act requirements.

There is strong debate nationally about the quality of work performed in physician office laboratories, but an informal study done by KMA shows that most physicians with high volumes of laboratory procedures could meet these standards, while the majority of laboratory tests performed in physicians' offices are quite elementary and appropriately do not require quality control. While the debate continues and some objective determinations do need to be made about physician office laboratories, the bill was seen as premature and not in the best interests of physicians, patients, or cost effectiveness. The legislation was defeated.

Another major issue considered by the Committee was home health neonatal visits. A proposal developed by some significant figures in the medical care community called for funding of neonatal visits by home health agencies for children who are recipients of the Medicaid Program. While the Committee was well aware of the importance of early neonatal visits to ensure proper care and followup, the proposal was met with mixed views. There was a question as to the cost effectiveness of the proposal, particularly in view of other demands on Medicaid funds. Ultimately, the plan was not funded by the Department. However, continued scrutiny needs to be given to this issue because of the alarmingly high rate of newborn deaths in the Medicaid population.

The Committee observed the progress of the KenPAC program and felt it to be developing well and to be well-accepted by both physicians and patients. While some inherent problems continue, the program has resulted in increased focus on primary care, a reduction in overutilization by patients, and some cost savings.

My thanks are extended to the other members of the Committee and all physicians who participate in Medicaid.

Harold L. Bushey, MD
Chairman

Report of the Committee on Community and Rural Health

The Community and Rural Health Committee met once during the Associational year with the majority of the discussion focusing on AIDS. Last year the KMA appointed an Ad Hoc Committee to Develop AIDS Guidelines at the request of the Kentucky General Assembly. The Ad Hoc Committee developed a document entitled "AIDS Policy Issues" and an informational document entitled "AIDS Guidelines." The Ad Hoc Committee completed its work, and the AIDS issue has been referred to the Community and Rural Health Committee, whose major charge is to deal with infectious diseases.

The Committee was advised that only one bill (HB 50) dealing with AIDS passed the 1988 Kentucky General Assembly. HB 50 prohibits persons exposed to or testing positive for the human immunodeficiency virus (HIV) and other specified health conditions from donating blood; defines blood establishments and requires that they be licensed by the U.S. Food and Drug Administration; limits charges for directed blood donations to twenty percent of the charge for a regular unit of blood; requires the units of blood collected for transfusion be affixed with a USFDA label, which includes a donor identification number through which specified information about the donor and testing of the blood can be obtained; requires each out-of-state unit of blood received

by an in-state blood establishment or health facility to contain a USFDA label; and relieves any health facility transfusing untested blood in an emergency situation from being liable in civil or criminal damages as long as consent has been obtained from the patient or next of kin. HB 50 appears to have placed some restrictions on autologous blood donations. KMA is working with the bill's sponsor, the Kentucky Hospital Association, and the Cabinet for Human Resources in resolving this issue.

Reginald Finger, MD, Communicable Disease Branch Manager, Kentucky Department of Health Services, reported to the Committee about the mailing of a pamphlet on AIDS. Under a mandate by Congress, 107 million copies of a booklet on AIDS information were mailed throughout the United States during the months of May and June. The eight-page booklet called "Understanding AIDS" is a simple, question-and-answer guide developed by the Centers for Disease Control. Copies of the booklet are available to physicians through the Kentucky Department of Health Services in Frankfort. A national hotline on AIDS has been established to answer questions. The toll free number is 1-800-342-AIDS. In Kentucky, the Department of Health Services has added extra telephone lines for questions concerning the booklet. Doctor Finger stated that one of the problems with the pamphlet is that it will not reach the high-risk population, such as the homeless and the illiterate.

It was agreed by the Committee that the entire AIDS issue is a current, critical, and on-going concern, and is one of a number of important issues to be addressed by the Community and Rural Health Committee on a continuing basis. The Committee also decided that new information concerning AIDS would be disseminated through the KMA *Journal* and "Communicator."

Doctor Finger reported on the two-tier system of validating school immunizations. He stated that each fall, surveys are mailed to the local health departments which are, in turn, given to the schools requesting information on their immunization levels. In the spring, the staff makes spot checks at the elementary schools validating immunization certificates.

The Committee was also advised that after July 1, the old HIB vaccine would no longer be available through the Kentucky Department of Health Services. The role of the Kentucky Department of Health Services is to make recommendations and answer questions concerning the HIB immunization, but not to provide any HIB vaccines. A new HIB vaccine is available at a cost of $13.75 per dose compared to $2.00 per dose for the old HIB vaccine. Doctor Finger told the Committee that funding for the remainder of the immunization program looks sufficient with total costs for vaccines at $2.5 million per year.

Doctor Finger also told the Committee that approximately 200 cases of Hepatitis A had been reported, of which 165 occurred in Jefferson County. The source of the epidemic was traced to restaurant salad bars which had received lettuce from Guatemala and Mexico.

The Committee continues to receive requests for copies of a pamphlet developed in 1985 on child abuse. Entitled "Recognizing and Reporting Child Abuse," the pamphlet was initially mailed to all physicians, hospitals, emergency centers, health departments, and public schools in the state to assist in recognizing and reporting child abuse.

On behalf of the Committee, we appreciate the opportunity to participate in the Association and to be of service to the members.

Ardis D. Hoven, MD
Chairman

Report of the Committee on School Health, Physical Education, and Medical Aspects of Sports

The Committee on School Health, Physical Education, and Medical Aspects of Sports sanctioned this year's Annual Medical Aspects of Sports Symposium in eight locations throughout the state, as follows:

Louisville — June 4, 1988
Elizabethtown — June 4-5, 1988
Lexington — June 11, 1988
Murray — June 11, 1988
Madisonville — June 17, 1988
Paris — July 14-15, 1988
Owensboro — July 16, 1988
Highland Heights — July 22-23, 1988

The different locations were scheduled by the Committee to make sessions more accessible for coaches due to the Board of Education directive that head coaches in high-risk sports of football, baseball, basketball, soccer, and wrestling, in order to maintain their certification, must annually attend at least one symposium sanctioned by the KMA Committee on School Health, Physical Education, and Medical Aspects of Sports.

A matter of grave concern is the lack of disciplinary measures for coaches who do not comply with this mandate. The Committee is considering asking the Superintendent of Public Instruction to work with the Board of Education in addressing this public health issue.

The seminars are designed to provide coaches with timely information and training to deal with medical emergencies involving athletes. The Committee requires that the seminars provide a minimum of seven hours of lectures, workshops, hands-on training, etc, and reviews the proposed programs prior to endorsement. CPR training, which is required by the State Board, is not included in the seven-hour time frame. Five regional areas opted for an extended one-day program this year rather than the normal two-day program.

To keep registration fees at affordable levels and provide continuity, the Committee set fees this year at $15 per registrant for one-day programs and $25 per person for two-

day programs. The Committee believes these fees will cover the basic costs and keep the seminars self-sufficient. Exceptions made to the fee requirements included two locations where financial assistance provided by hospitals, universities, and pharmaceutical companies permitted reduced fees.

The Committee appreciates the time and dedication provided by those who planned and coordinated the seminars this year and those people who participated in the programs.

We were fortunate during this Associational year to receive over $1,900 in contributions toward the printing of the "Athletic Drug Problems" brochure developed by the Committee. These contributions have allowed us to provide 50,000 brochures to Kentucky athletes, which were distributed to coaches at the various seminars for their teams. In addition, brochures were provided directly to athletes in regional, district, and state competitions in several sports. We appreciate the cooperation of the Kentucky High School Athletic Association, the Kentucky Medical Insurance Company, and those in charge of the seminars in assisting with our distribution efforts. While not all athletes have been reached, the Committee is confident that this has been a successful program, and the response to the brochure by students, coaches, and trainers has been overwhelming. Distribution will continue as funding is received.

The Committee is currently working on the development of a "Sports Medicine Syllabus and Program Guide" for the purpose of providing a basic level of instruction in various aspects of sports medicine as they relate to the needs of coaches. A subcommittee has been appointed to oversee the development of the Syllabus, and assigned participants are currently preparing the material. As soon as all papers are completed and reviewed by the subcommittee, suggestions will be made on methods of providing this information to coaching staffs as a ready reference manual. The Committee believes this will also serve as an effective guide in the program development for the sports medicine seminars.

Several Committee members were contacted regarding two potential problems in football. The first is a matter of late whistles, which often results in injuries. Concern was expressed about the hesitancy of referees to stop play after whistles have been blown and strictly enforce this rule. The second problem is spearing. Spear tackling, for the uninitiated, is using the helmet as the first and primary contact in tackling, particularly against offensive players already on the ground, to prevent forward progress. This technique is a violation and can cause death or neck injuries resulting in an athlete becoming permanently disabled. The Committee has requested that the Kentucky High School Athletic Association provide assistance in eliminating these potentially hazardous situations.

As a matter of interest, the State-appointed Advisory Council for Sports Medicine will soon be holding a planning meeting with the new Superintendent of Public Instruction to discuss the possibility of seeking funding in the 1990 Legislative Session for the Athletic Trainers' Program. Legislation passed by the 1986 Kentucky General Assembly created the mechanism to provide for teacher-trainers to develop sports medicine programs that will improve the health care and safety of student athletes, but no funding was provided. It had been hoped that private funding could be obtained for this project. KMA is represented on the Advisory Council for Sports Medicine.

The Committee on School Health, Physical Education, and Medical Aspects of Sports appreciates the cooperation it receives from Kentucky's coaches, trainers, principals, the Superintendent of Public Instruction, the State Board of Education, and the Kentucky High School Athletic Association, in helping us monitor the safety of students. As Chairman, I am grateful for the continuing interest, enthusiasm, and active involvement of the members of this Committee.

R. Quin Bailey, MD
Chairman

Report of the Advisory Committee to CHR

The Advisory Committee to the Cabinet for Human Resources (CHR) did not hold a formal meeting this year. However, Officers and other representatives of KMA have met with the Secretary on issues which included medical insurance program provisions, indigent care, and a physician voluntary assignment program.

The Advisory Committee exists, essentially, to discuss urgent policy matters with the Secretary. While a number of significant issues have developed or evolved this year, nothing of an urgent nature required a formal meeting.

William B. Monnig, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Committee on Maternal and Child Health

The Committee on Maternal and Child Health met on July 13, 1988, to discuss programs of interest and receive status reports on matters in which the Committee has been involved.

Kentucky has a high rate of teenage pregnancies and, according to the latest statistics, births to the fifteen-and-under age group are not decreasing. As a result, in 1986 the Maternal and Child Health Committee recommended the endorsement of sex education programs in the school system. The House of Delegates approved that recommendation.

The Kentucky Department of Education has also identified teenage pregnancy as a major problem. That department and Gene Fitzhugh, its Health Education Consultant, have been looking at sex education programs as a possible

solution to this problem. The KMA Maternal and Child Health Committee has been in periodic contact with the Department of Education offering support and assistance in those efforts.

We are pleased to report that the 1988 Kentucky General Assembly passed House Bill 345, Parenting and Family Life Skills, which mandates that effective September 1, 1989, every school district in Kentucky must provide family life instruction, to include sex education, for students in grades K-12. The Committee feels this will aid in the reduction of teenage pregnancies.

Mr. Fitzhugh attended the July 13 meeting of the Committee and provided information on the Department's implementation of HB 345. A 27-member task force has been appointed; Thomas L. Young, MD, a Lexington pediatrician, is the only physician member of this task force. Public hearings have been held by the task force, although they were not well publicized. A curriculum committee is currently developing guidelines for the 178 school districts to use in setting up individual plans of instruction, which must be approved by the Department of Education.

Kentucky is one of seven states with a sex education/family life skills program of this magnitude, and implementation will not be an easy task. The General Assembly did not appropriate funding for this program, and the money that is available will come through the Division of Maternal and Child Health. AIDS education money in the amount of $120,000 is available and, since AIDS education will be a part of the total program, that money can be used in the training of teachers to address the subjects of AIDS and other sexually transmitted diseases.

Each school district must have in place by September 1, 1988, an advisory task force to be composed of various professionals and parents. The advisory task force is to assist the local school districts in drawing up and carrying out the education plans.

Mr. Fitzhugh noted that HB 345 also calls for the Department of Education to develop a method of measuring the effectiveness of the curriculum in each local school district, including the setting of reasonable goals for the reduction of sexual activity, sexually transmitted diseases, and premarital pregnancy by the 1994-95 school year.

He requested from KMA assistance in implementing the sex education program through physician involvement at the local level. The Maternal and Child Health Committee reiterated KMA's position in support of sex education and the strong belief that physicians should be involved in this instruction. The Committee noted that members of the Auxiliary to KMA might also be willing to assist. Approval from the Board of Trustees has been secured by the Committee for active participation by KMA in the following manner:

1. Correspond with county medical societies encouraging local physicians to offer assistance to local school boards as consultants or participants in the development and presentation of sex education programs in their areas.

2. Correspond with all Kentucky school superintendents notifying them that local physicians in their areas should be involved and most likely would be willing to participate.

3. Correspond with the Department of Education again offering the assistance of KMA and its membership.

4. Correspond with the Cabinet for Human Resources offering assistance in this area.

5. Publish in "The Communicator" and the *Journal* information on the mandatory sex education program to include encouragement for each KMA member to offer assistance at the local level.

The Maternal and Child Health Committee had suggested, and the House of Delegates approved, that KMA recommend to the Cabinet for Human Resources that funding be expanded for obstetrical care of the indigent of Kentucky. Meetings with the Secretary for Human Resources and the Medicaid Division, as well as expanded funding, have finally produced an increase in reimbursement for obstetrical deliveries from $250 to $650 for routine deliveries and cesarean sections by Board-certified obstetricians-gynecologists. Janie Miller, Deputy Commissioner for the Division for Medicaid Services, attended the meeting in July and reported that payment now represents approximately 70% to 75% of delivery fees. She also reported that beginning in October of 1988, Medicaid will cover 125% of the federal poverty level. An estimated $6.2 million will be required for preventive services through local health departments for prenatal and postnatal care, high risk coordination, genetic counseling, etc.

Pat Nicol, MD, Director of the Maternal and Child Health Division of CHR, provided information on the number of infant mortalities of Medicaid patients as compared to total population.

Mrs. Miller discussed a newborn monitor program through home health agencies for tracking and improving the care of high-risk infants, noting there has been mixed feedback from the medical community in regard to the effectiveness of this program due to concern about the quality of care provided by home health agencies. She also discussed a prenatal monitoring of 17 Medicaid patients on a trial basis through the use of the Tocos vaginal device. The average patient cost is $4,000 to $5,000, and the device is not reusable. Data on the 17 patients is being compiled, and the Division of Medicaid Services is reevaluating this program for cost effectiveness. Mrs. Miller asked for input from the Maternal and Child Health Committee, and we have asked the Kentucky OB-GYN KOGS — Kentucky Section of ACOG to provide its opinion on the validity and effectiveness of this device.

The Committee also discussed the limitation on hospitalization to two postpartum days for Medicaid patients, feeling strongly this limitation is unwise. Mrs. Miller indicated extension of hospitalization could be considered, but Medicaid would need criteria on which to base an extended stay. We have also asked the Kentucky OB-GYN KOGS — Kentucky Section of ACOG to assist in the development of this criteria. The Committee recommends to the House of Dele-

gates that KMA go on record in opposition to any arbitrary limitation on the number of days of patient postpartum care since the determination of this care should be based on medical necessity.

The University of Kentucky has been without a maternal transport program for some time. KMA is on record in support of a transport program at UK for its area of the state, as well as a strong perinatal program. Wayne Conover, MD, the Director of UK's Maternal and Fetal Medicine Program, is fairly new to that position and has been actively involved in strengthening high-risk obstetrical services. We are pleased to report that UK has begun a maternal transport system, although there are still some problems to be resolved.

Last year the Committee recommended, and the House approved, support for the use of a new U.S. standard birth certificate, as presented to us for approval by the Vital Statistics Division of CHR. The form contains questions that can be answered by use of a check-box method.

The Director of Vital Statistics, Omar Greeman, provided us with a brief report on the use of the new form. Much better information is being received, according to Mr. Greeman, and during 1989 the Vital Statistics Division hopes to have base-line data on risk factors, complications, and malformations, which can be correlated with sociometric data, such as age, race, low birth weight, previous deliveries, and prenatal care. Mr. Greeman further reports that if the high infant mortality rate in this country is a social rather than a medical problem, as it is believed, such correlations will provide guidance in identifying those populations where a few hundred dollars in prenatal care will negate the need for $1,000 per day for neonatal care.

While KMA has approved the certificate and has encouraged physicians to cooperate in filling out the form as completely as possible, our Committee has learned that a number of physicians are leaving the check-box questions unanswered. These questions are important in providing information to the Division of Vital Statistics, and the Maternal and Child Health Committee recommends that KMA once again encourage each physician to provide the needed information by completing the form in its entirety. The information is held confidential.

The Committee received information about a training program sponsored by the University of Kentucky which gives instruction on neonatal CPR. The Committee strongly endorses this UK program, provided through the Department of Pediatrics, and would encourage all physicians involved in neonatal care to pursue and acquire such instruction.

Danny M. Clark, MD
Chairman

RECOMMENDATIONS:

1. The Committee recommends to the House of Delegates that KMA go on record in opposition to any arbitrary limitation on the number of days of patient postpartum care since the determination of this care should be based on medical necessity.
2. The Maternal and Child Health Committee recommends that KMA once again encourage each physician to provide the information needed by the State Division of Vital Statistics by completing the U.S. standard birth certificate in its entirety.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 considered the Report of the Committee on Maternal and Child Health. It was noted that the Kentucky General Assembly passed HB 345 mandating Parenting and Family Life Skills (including sex education) in public schools. It is hoped that all physicians and county medical societies will become involved in the implementation of these programs at a local level, as recommended by Report No. 31.

It is recommended that Report No. 31 and its two Recommendations be adopted.

Special Report A
Physician Voluntary Medicare Assignment Program

Addendum to the Report of the Chairman, Board of Trustees

Medical care costs in the country continue to rise. This rise can be attributed to a variety of factors, but the trend appears to be continuous. The Medicare Program, which directly or indirectly funds approximately 40% of all medical care provided in the country, has obviously felt the impact of rising costs and has been the target for cost containment and reduction measures by Congress to a significant degree over the past five-year period. Many of these cost reduction efforts have resulted in increased out-of-pocket expenditures by Medicare recipients. This proposal is a measure to try to ameliorate the problems faced by the elderly in finding access to care. Like the Kentucky Physicians Care Program (KPCP), it calls for voluntary participation by physicians, the aid of the Kentucky Health Care Access Foundation, and the assistance of the Cabinet for Human Resources (CHR).

Current Medicare Status

Title XVIII of the Social Security Act, Medicare, establishes a program to provide medical care to citizens aged 65 and older who qualify for Social Security. During each calendar year, recipients must pay a hospital deductible of approximately $570 and a physician deductible of approximately $70. Once these deductibles are paid, the Medicare Program covers approximately 90% of hospital costs and approximately 60% of physician charges. Because of decreasing hospital and phy-

sician payments and other program restrictions, patients are being forced to expend considerable out-of-pocket assets to meet medical bills.

Physician Participation in Medicare

Through Medicare, physician reimbursement is based on a percentage of historical charges. A very complicated formula is used to derive physician payments, and minimal increments have been allowed over the years, not including two periods of *fee freeze* in the late 70s and in 1983-84. Physicians *may* be *participating physicians* with Medicare. Participating physicians sign a formal contract with the Medicare carrier, which means they will accept whatever Medicare pays for a given procedure as payment in full. *However, Medicare only pays physicians 80% of the "full" or "allowable" charge, and the patient is required to pay the difference to the physician. Cooperation in the Voluntary Assignment Program (VAP) does not release physicians from the responsibility to bill patients for the 20% co-insurance charge under Medicare. Routine waiving of the co-insurance is prohibited by HCFA.*

Incentives for being a participating physician are that the physician is paid directly by Medicare; lists of participating physicians are provided to patients; and participating physicians, in the last two years, have received larger allowable increases, amounting to approximately 3% over previous totals. *Nonparticipating physicians* charge their full fee to the patient. Medicare reimburses the patient the *allowable* amount, and the patient is expected to pay that amount plus the remaining difference of the physician's full fee. (This figure, too, is restricted to fees charged during a base period in 1984. Nonparticipating physicians' fees are held to the level of fees charged during that base period in spite of a lengthy suit brought by the American Medical Association.)

In fact, many physicians who are not participating often accept assignment, depending on the individual financial circumstances of the patient. According to the Medicare carrier in Kentucky, 78% of all Medicare claims are *assigned.* This means that of all procedures performed by Kentucky physicians, regardless of whether or not they participate, 78% of the time physicians will accept Medicare payment as payment in full. In addition, over 55% of all Kentucky physicians have signed participation agreements. Just as in the KPCP, doctors in the Commonwealth are providing care. However, there remains a general perception, especially at the Congressional level, that physicians are not assuring care to the elderly. To help dispel this perception, the Kentucky Medical Association proposes to establish a Voluntary Assignment Program (VAP) for Medicare patients in the spirit of the KPC Program.

Recently, the President signed a catastrophic Medicare Bill which would expand benefits. The bill provides that no Medicare recipient will be required to pay out-of-pocket expenses for Medicare services that exceed approximately $1,300. This expanded provision will be funded by an increased premium paid by patients, graduated according to income. The effect of this bill is unknown. It has been suggested that the bill will not affect 93% of current Medicare patients, but increased premiums may offset any supposed savings.

VOLUNTARY ASSIGNMENT PROGRAM

Eligibility

All patients aged 65 or older who are current beneficiaries of the Medicare Program and who have incomes up to 100% of the Federal Poverty Level (FPL) will be eligible for the VAP. This is $5,770 for a single person and $7,730 for a two-person family.

Deductibles and Copayments

Experience observed in programs of other states has shown that Federal law prevents waiving deductibles and copayments that must be made by patients. Deductibles are determined and assessed by the carrier; copayments are made by the patient to the physician.

Physician Participation

All physicians will be asked to become participants in the program, whether they currently are participating or nonparticipating physicians in Medicare. If a physician becomes a participant in the VAP, he will agree to accept Medicare payment as payment in full for a service to patients who are eligible. The physician must still bill patients the co-insurance charge of 20% of their allowable charge on all claims and any deductibles. These amounts may be waived ONLY if the patient notifies the physician in writing, for safety's sake, that he or she is unable to pay the balance.

Eligibility Determinations

Eligibility determinations will be made by an appropriate agency of state government, as is currently the case with KPCP. Patients seeking treatment through the program will be screened by a state office, provided with VAP identification, and referred to the Kentucky Medical Association for determination of a physician. Screening will have to include the presence and value of supplementary insurance.

Eligibility determinations could be done by the Division of Aging, which already does a considerable number of screening functions. If done by the Division of Aging, screening could possibly be done through Area Development Districts.

Program Operation

Once a patient has become eligible, he can contact KMA by a toll free number and be advised of VAP physicians in his area. The patient must then contact the physician and make necessary treatment arrangements. KMA will solicit Kentucky physicians to acquire their participation and will

develop a list, by location, from which patients may choose physicians. The administrative process and personnel currently used by the KPCP will be utilized to administer the VAP. This will require the ongoing financial assistance of the Kentucky Health Care Access Foundation, which should not exceed the level now required for the Kentucky Physicians Care Program.

There are approximately 516,000 Medicare recipients in Kentucky. It is not known what percentage of this number have income totalling 100% of the FPL or below. Over 78% of all Medicare claims are accepted on assignment, as mentioned earlier. Also mentioned earlier was the recent enactment of Federal legislation which would preclude out-of-pocket payments of *catastrophic* expenses. Regardless of the number of patients who might finally be eligible and seek care through the VAP, KMA feels obligated to develop and operate the program. It is current KMA policy, which was affirmed at the most recent meeting of the House of Delegates, to "encourage physicians to accept Medicare assignment based on the individual circumstances of the patient." It is a subjective impression that this obligation is now being met, but formation of the VAP will formalize the issue and underscore the commitment of physicians to assuring the availability of care to the elderly in our state.

RECOMMENDATIONS

1. It is recommended that the concept and operation of the Voluntary Medicare Assignment Program be approved by the House of Delegates and that the Program be put into effect. Conduct of the Program will be contingent on the cooperation of state government and the Health Care Access Foundation.

Resolution I

Voluntary Medicare Assignment
Jefferson County Medical Society

WHEREAS, policy of the AMA is that physicians be encouraged to consider each patient's ability to pay, and

WHEREAS, the Kentucky Physicians Care Program has been highly successful and widely recognized in ensuring and documenting that needy patients receive required medical care, and

WHEREAS, many elderly patients have adequate assets and ample resources to pay for their needed medical care, now therefore be it

RESOLVED, that the Kentucky Medical Association study the feasibility of expanding the Kentucky Physicians Care Program to include voluntary acceptance of Medicare assignment for elderly patients who have documented their financial need to an appropriate certifying organization.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Report No. 5, Report of the Chairman, Board of Trustees, Special Report A — Physician Voluntary Medicare Assignment Program, **only**, and Resolution I, Voluntary Medicare Assignment, submitted by the Jefferson County Medical Society. Testimony was heard and a number of concerns voiced, including a lack of knowledge of the number of patients involved, the method of assignment of patients to physicians, and the management of the required copayments.

The Reference Committee recommends that the "Resolved" of Resolution I be amended by addition as follows:

"RESOLVED, that the Kentucky Medical Association further study the feasibility of expanding the Kentucky Physicians Care Program to include voluntary acceptance of Medicare assignment for elderly patients who have documented their financial need to an appropriate certifying organization."

Reference Committee No. 5 recommends that Resolution I, as amended, be adopted in lieu of the Recommendation of Special Report A.

Reference Committee No. 5 further recommends that Report No. 5, Report of the Chairman, Board of Trustees, Special Report A — Physician Voluntary Medicare Assignment Program, **only**, be filed.

Resolution B

Tobacco-Free Schools
Fayette County Medical Society

WHEREAS, the Surgeon General of the United States has established the goal of a smoke-free society by the year 2000, and

WHEREAS, scientific data validate the fact that tobacco in all forms constitutes a major health hazard, and

WHEREAS, medicine is vitally concerned with health promotion and the reduction of risks and hazards to health, now therefore be it

RESOLVED, that the Kentucky Medical Association support the concept of tobacco-free Kentucky schools (kindergarten through high school).

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Resolution B, Tobacco-Free Schools, submitted by Fayette County Medical Society. The Committee recommends that Resolution B be adopted.

Resolution C

Child Car Seat Safety
Fayette County Medical Society

WHEREAS, Kentucky law now requires that any resi-

dent parent or legal guardian of a child, forty inches (40″) in height or less, when transporting his child in a motor vehicle owned by that parent or guardian operated on the roadways, streets, and highways of this state, shall have such child properly secured in a child restraint system of a type meeting Federal motor vehicle safety standards, and

WHEREAS, there is documentation that the use of child restraining seats reduces the risks of fatality and severe injuries, and

WHEREAS, the Fayette County Medical Society has initiated a "Child Car Seat Safety" campaign to encourage the use of car seats, and

WHEREAS, the FCMS campaign also urges the donation by local citizens of car seats which are clean and in good repair so that they are available for those citizens unable to purchase new car seats, now therefore be it

RESOLVED, that the Kentucky Medical Association encourage all county medical societies in Kentucky to develop child car seat safety programs in their communities, and be it further

RESOLVED, that the Kentucky Medical Association assist all component societies in the implementation of child car seat safety programs.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Resolution C, Child Car Seat Safety, submitted by Fayette County Medical Society. The Committee recommends that Resolution C be adopted.

Resolution G

Out-of-State School Physical Examination Requirements
Jefferson County Medical Society

WHEREAS, House Bill 527 amended KRS 158.035 to allow medical or osteopathic physicians duly licensed in any state to complete the immunization certificate, but the Kentucky Department of Education, through its regulatory authority, is requiring all students to have a Kentucky immunization certificate, and

WHEREAS, proof that a school physicial examination was given six months prior to or one month following initial admission to school must be recorded on the Kentucky Department of Education form, "School Medical Examination Form 1671-410," and

WHEREAS, these requirements exceed the requirements of the law and create needless paperwork burdens and unproductive expense for school systems, physicians, and their patients without any additional enhancement of public health, now therefore be it

RESOLVED, that the Kentucky Medical Association work jointly with the State Board of Health and the State Board of Education to ensure that documentation of out-of-state physical examinations and immunization records be permitted to be made in a reasonable manner so as not to create needless paperwork burdens or unproductive expenses for school districts, physicians, and their patients.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Resolution G, Out-of-State School Physical Examination Requirements, submitted by Jefferson County Medical Society. Reference Committee No. 5 recommends that the "Resolved" be amended as follows:

"RESOLVED, that the Kentucky Medical Association work jointly with the [State Board of Health] Cabinet for Human Resources and the State Board of Education to ensure that documentation of out-of-state physical examinations and immunization records be permitted to be made in a reasonable manner so as not to create needless paperwork burdens or unproductive expenses for school districts, physicians, and their patients."

Reference Committee No. 5 recommends that Resolution G be adopted as amended.

Resolution H

Enforcement of Laboratory Regulations
Jefferson County Medical Society

WHEREAS, a well-known grocery chain recently conducted a highly promoted project of taking blood samples on its premises and offering shoppers in its grocery stores blood test results, and

WHEREAS, it would appear from a review of KRS Chapter 333 that the services being offered by the supermarket chain constitute the collection and examination of human blood to obtain information for diagnosing, preventing, or treating disease, or in which the results of any examination, determination, or tests are used as a basis for health advice, and

WHEREAS, if true, it would also appear that the facility in which these procedures are performed must be licensed, and

WHEREAS, it would appear that the Kentucky law would permit such a facility to examine human specimens only at the request of a licensed physician or other person authorized by law to use the findings, and that the results of such tests are to be reported directly to a licensed physician, now therefore be it

RESOLVED, that the Kentucky Medical Association encourage the appropriate state authorities to promote high quality patient care through the enforcement of Chapter 333 of the Kentucky Revised Statutes.

Recommendations, Reference Committee No. 5:

Reference committee No. 5 next considered Resolution

H, Enforcement of Laboratory Regulations, submitted by Jefferson County Medical Society. The Committee recommends that Resolution H be adopted.

Resolution O

DRGs
Fayette County Medical Society

WHEREAS, prospective payments by diagnostic related groups (DRGs) have been imposed on hospitals for Medicare patients as a cost containment measure, and

WHEREAS, DRG payments have resulted in a very significant loss of revenues for many hospitals with a large percentage of Medicare patients, particularly those hospitals with a disproportionate number of seriously ill patients due to nonreimbursed care, and

WHEREAS, this loss of revenues has seriously affected the financial viability of many of the hospitals in Kentucky, both rural and urban, and

WHEREAS, the demise of these hospitals would result in a severe restriction in the access to medical care for all Kentuckians, now therefore be it

RESOLVED, that the Kentucky Medical Association go on record as being opposed to the current DRG prospective payment system and support a return to a conventional reimbursement system, and be it further

RESOLVED, that the Kentucky Medical Association encourage the American Medical Association and Kentucky's federal legislators to work to repeal the DRG payment system.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Resolution O, DRGs, submitted by Fayette County Medical Society. The Committee recommends that Resolution O be adopted.

Resolution Q

Patient Copayments for Hospitalized Medicare Patients
Bell County Medical Society

WHEREAS, the first-day copayment for Medicare patients entering a hospital and lacking any coinsurance is a hardship for many, and

WHEREAS, once admitted, Medicare's payment of the entire balance of the bill gives patients no financial motive to shorten their stay, now therefore be it

RESOLVED, that the first-day patient copayment for Medicare patients should be reduced and a small copayment for each subsequent day in the hospital should be established, and be it further

RESOLVED, that to make these provisions fully effective in discouraging hospital utilization, the copayment should be withheld in installments from pension checks, and be it further

RESOLVED, that the Kentucky Medical Association communicate these recommendations to the Health Care Financing Administration.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Resolution Q, Patient Copayments for Hospitalized Medicare Patients submitted by Bell County Medical Society.

Reference Committee No. 5 recommends that the second "Resolved" of Resolution Q be deleted, and that the third "Resolved" of Resolution Q be amended to read as follows:

"RESOLVED, that the Kentucky Medical Association communicate [~~these~~] this [~~recommendations~~] recommendation to the Health Care Financing Administration."

Reference Committee No. 5 recommends the adoption of Resolution Q as amended.

The motion was seconded from the floor and carried. Resolution Q adopted as amended, reads as follows:

WHEREAS, the first-day copayment for Medicare patients entering a hospital and lacking any coinsurance is a hardship for many, and

WHEREAS, once admitted, Medicare's payment of the entire balance of the bill gives patients no financial motive to shorten their stay, now therefore be it

RESOLVED, that the first-day patient copayment for Medicare patients should be reduced and a small copayment for each subsequent day in the hospital should be established, and be it further

RESOLVED, that the Kentucky Medical Association communicate this recommendation to the Health Care Financing Administration.

Resolution S

Childhood Immunizations
Jefferson County Medical Society

WHEREAS, KenPAC requires the primary care physician to attempt to manage the health care of the Medicaid recipient, and

WHEREAS, routine childhood immunizations are a vital component of that health care, and

WHEREAS, reimbursement to the primary care physician for required childhood immunizations is currently not provided by the Medicaid or KenPAC programs, and

WHEREAS, this imposes a second step for Medicaid recipients to receive these immunizations in the form of a visit to the Health Department clinics, and

WHEREAS, there is no federal limitation for providing these services, now therefore be it

RESOLVED, that the Kentucky Medical Association strongly encourage the Secretary for Human Resources to

provide reimbursement at cost plus an administrative fee for these services, provided in the primary care physician's office under the Medicaid and KenPAC provisions of service.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Resolution S, Childhood Immunizations, submitted by Jefferson County Medical Society.

Concern was voiced that the cost for the immunizations could be considerably higher in the primary care physician office than those furnished through the health department. The Committee recommends that Resolution S be referred to the Board of Trustees for further review.

The motion was seconded from the floor. William B. Monnig, Board Chairman, made a motion that Resolution S be adopted rather than referred. The motion to adopt Resolution S was seconded and carried.

Resolution V

Disposal of Medical Waste
KMA Board of Trustees

WHEREAS, there has been recent publicity over improperly disposed of medical waste washing ashore on the east coast, and

WHEREAS, there have been reports of children playing with contaminated needles or other material in inland cities, and

WHEREAS, the AIDS virus and its potential for disaster make appropriate disposal of contaminated materials literally a life-and-death issue, now therefore be it

RESOLVED, that the Kentucky Medical Association condemn the disposal of hazardous medical waste in any fashion which might be harmful or dangerous to humans, animals, or the environment, and be it further

RESOLVED, that the Kentucky Medical Association support the efforts of the Kentucky Infectious Waste Task Force to develop guidelines and/or regulations governing the disposal of hazardous medical waste materials in Kentucky.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Resolution V, Disposal of Medical Waste, submitted by the Board of Trustees. Reference Committee No. 5 recommends that Resolution V be adopted.

Resolution AA

Patient Counseling
KMA Board of Trustees

WHEREAS, the diagnosis and spread of AIDS is growing at an alarming rate, and

WHEREAS, there is general apprehension among the public regarding AIDS and AIDS prevention measures, and

WHEREAS, educating the public, particularly HIV positive patients, is a professional responsibility of the medical profession, now therefore be it

RESOLVED, that physicians diagnosing patients as HIV positive counsel their patients as to the ramifications of AIDS or refer patients to the appropriate specialist or governmental agency for counseling, and be it further

RESOLVED, that KMA urges its members to actively pursue scientific knowledge and data regarding AIDS and that KMA cooperate with the Kentucky Cabinet for Human Resources, medical schools, and other scientific and governmental agencies in providing educational opportunities for physicians, health providers, and other agencies and personnel counseling and treating HIV positive and AIDS patients.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Resolution AA, Patient Counseling, submitted by the Board of Trustees. Reference Committee No. 5 recommends that Resolution AA be adopted.

Resolution BB

Health Department Ambulatory Care Program
KMA Board of Trustees

WHEREAS, primary ambulatory medical care is most appropriately rendered by physicians, who constitute the nucleus of the medical community, and

WHEREAS, a proposal has been developed by the Department for Health Services to provide routine "unrestricted" medical services through local health departments, and

WHEREAS, health departments are incapable of providing an adequate continuum of medical services, and this proposal is medically inappropriate, and

WHEREAS, this House of Delegates has previously taken a position in opposition to such a proposal as have the committees of jurisdiction of the Kentucky General Assembly, and

WHEREAS, this proposal could have a significant negative effect on the medical welfare of patients and the financial resources of the state devoted to medical care, now therefore be it

RESOLVED, that local health departments should continue to fulfill their traditional public health mission, and be it further

RESOLVED, that this House of Delegates reaffirm its opposition to the routine delivery of ambulatory services through health departments, and be it further

RESOLVED, that KMA oppose any such programs through administrative regulatory, and legislative channels, and through those channels exercise whatever influence possi-

ble to assure that "unrestricted" medical services are rendered only by physicians and only in appropriate settings.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Resolution BB, Health Department Ambulatory Care Program, submitted by the Board of Trustees.

Testimony was heard from a number of interested parties. It was the consensus that members of the Kentucky Medical Association should continue to maintain a satisfactory interrelationship with local health departments, but that local health departments should function within the boundaries of the traditional public health service mission.

Reference Committee No. 5 recommends that the second "Resolved" of Resolution BB be amended to read as follows:

"RESOLVED, that this House of Delegates [r e a f f i r m] affirm its opposition to the proposed plan of the Department for Health Services to provide [p r o v i d e] routine unrestricted [ambulatory] medical services through local health departments."

Reference Committee No. 5 also recommends that the third "Resolved" of Resolution BB be deleted.

Reference Committee No. 5 recommends the adoption of Resolution BB as amended.

The motion was seconded from the floor and carried. Resolution BB, adopted as amended, reads as follows:

WHEREAS, primary ambulatory medical care is most appropriately rendered by physicians, who constitute the nucleus of the medical community, and

WHEREAS, a proposal has been developed by the Department for Health Services to provide routine "unrestricted" medical services through local health departments, and

WHEREAS, health departments are incapable of providing an adequate continuum of medical services, and this proposal is medically inappropriate, and

WHEREAS, this House of Delegates has previously taken a position in opposition to such a proposal as have the committees of jurisdiction of the Kentucky General Assembly, and

WHEREAS, this proposal could have a significant negative effect on the medical welfare of patients and the financial resources of the state devoted to medical care, now therefore be it

RESOLVED, that local health departments should continue to fulfill their traditional public health mission, and be it further

RESOLVED, that this House of Delegates affirm its opposition to the proposed plan of the Department for Health Services to provide routine unrestricted medical services through local health departments.

Resolution CC

Weekend Transfer from Hospital to Nursing Home
Warren County Medical Society

WHEREAS, transfer of patients from hospital to nursing home is frequently delayed by administrative red tape in both hospital and nursing home, and

WHEREAS, this results in unnecessary cost to the patient and/or his third-party insuror, now therefore be it

RESOLVED, that the KMA Board of Trustees suggest to appropriate governmental officials and Kentucky nursing home officials a cooperative effort on the part of Kentucky hospitals and physicians to expedite transfer of patients on weekends for the convenience of the patient and his or her family, as well as the substantial savings from unnecessary extension of hospital days.

Recommendations, Reference Committee No. 5:

Reference Committee No. 5 next considered Resolution CC, Weekend Transfer from Hospital to Nursing Home, submitted by Warren County Medical Society.

Reference Committee No. 5 recommends that the "Resolved" of Resolution CC be amended to read as follows.

"RESOLVED, that the KMA Board of Trustees suggest to appropriate governmental officials and Kentucky nursing home officials a cooperative effort on the part of Kentucky hospitals and physicians to expedite transfer of patients [o n w e e k e n d s] any day of the week for the convenience of the patient and his or her family, as well as to realize the substantial savings from unnecessary extension of hospital days."

Reference Committee No. 5 recommends the adoption of Resolution CC as amended.

Mr. Speaker, Reference Committee No. 5 recommends the adoption of the Report of Reference Committee No. 5 as a whole, as amended.

I would sincerely like to thank the other members of the Committee, Thomas E. Bunnell, MD, Erlanger; William D. Medina, MD, Lexington; Charles C. Moore, MD, Middlesboro; and William C. VonderHaar, MD, Louisville. I would also like to thank Sharon McCrary for her assistance in the preparation of this Report.

Reference Committee No. 5

Scott B. Scutchfield, MD, Danville, Chairman
Thomas E. Bunnell, MD, Erlanger
William D. Medina, MD, Lexington
Charles C. Moore, MD, Middlesboro
William C. VonderHaar, MD, Louisville

Editorial Note: Unless otherwise noted, the Reference Committee action on each Report and Resolution was accepted as printed. Any opposing action taken is stated in discussion following the item.

REPORT OF REFERENCE COMMITTEE NO. 6

Harold D. Haller, Sr, MD, Louisville, Chairman

Reference Committee No. 6 considered the following Reports and Resolution:

36. Report of the Judicial Council
37. Report of the Rural Kentucky Medical Scholarship Fund
38. Report of the Physician-Attorney Liaison Committee
39. Report of the Membership Committee
40. Report of the Committee on Constitution and Bylaws
41. Report of the McDowell House Board of Managers
42. Report of the Medical Student Section
43. Report of the Resident Physicians Section
5. Report of the Chairman, Board of Trustees, Report of the Young Physicians Steering Committee, **only**

Resolution J — ACLS and BCLS Certification for Residents (Resident Physicians Section)

ITEMS FOR CONSENT

Reference Committee No. 6 reviewed the following items and recommends they be filed by consent of the House, without discussion:

36. Report of the Judicial Council — filed
37. Report of the Rural Kentucky Medical Scholarship Fund — filed
39. Report of the Membership Committee — filed
40. Report of the Committee on Constitution and Bylaws — filed
41. Report of the McDowell House Board of Managers — filed
42. Report of the Medical Student Section — filed
43. Report of the Resident Physicians Section — filed
5. Report of the Chairman, Board of Trustees, Report of the Young Physicians Steering Committee, **only** — filed

Mr. Speaker, Reference Committee No. 6 recommends adoption of the Consent Calendar as a whole.

Report of the Judicial Council

The Judicial Council has met every two months this year and continues to serve as the final arbiter of ethics on behalf of the membership.

While patient complaints have not significantly abated from previous years, there seems to be an increase in physicians questioning the behavior of other physicians. It is thought that the increased incidence of this sort of question arises not so much from competition, as from restrictions caused by various administrative requirements which influence medical practice.

To address this issue, Legal Counsel, at the direction of the Judicial Council, developed a document which discusses physicians' responsibility to patients under cost containment plans. The document was drafted, referred to the Board of Trustees which approved it, and was printed in the KMA *Journal*.

Along similar lines, the Council considered the issue of joint ventures between physicians and medical facilities, partly on request from the Board of Medical Licensure. A number of instances were suggested by members, and the Council felt that this matter did deserve some thoughtful analysis. Finally, the Council developed the opinion that joint ventures between physicians and facilities need to be considered individually, but any compensation or inducements received by a physician for participation in a joint venture which would prove detrimental to the patient, either through inappropriate care or unnecessary treatment, would be a violation of ethics. The Council intends to continue monitoring this matter.

Also related to medical practice issues was a request from a member asking the Council to consider the physician's responsibility to see a patient when the physician was on an hourly contract with a clinic and the patient presented for treatment outside contracted hours. In addition, the question was raised as to whether a physician could refuse to treat a patient due to an outstanding bill. The Council rendered the opinion that if a physician has treated a patient and the patient subsequently presents at the hospital emergency room, the physician should respond, unless other coverage was provided after hours by the clinic. The patient should not be refused treatment in an emergency situation. If a physician plans to discontinue treatment because of a bill due, the patient should be notified and given time to find another source of treatment.

Another matter considered related to the physician treating himself or family members. The Council rendered the opinion that, except in emergency situations, physicians should not attempt to treat themselves or family members for serious illnesses or injuries, as the physician's emotional involvement might affect his objectivity and impair medical judgment. The Council further declared that charging for services performed on one's self or family members would be inappropriate.

On a related practice issue, a physician registered a complaint about advertising by nonphysician medical personnel. The Council determined that it had no jurisdiction over nonphysicians, but did refer the matter to the Board of Medical Licensure. It was learned that a Kentucky Attorney General's opinion rendered in 1982 held that advertising by nonphysicians which related to physician-like medical care was a violation of the Medical Practice Act.

On a broader matter, the Council considered at length the current status of appropriate ethical behavior for physicians relating to the AIDS issue. The Council adopted the AMA policy on AIDS, which in summary states: (1) a physician may not ethically refuse to treat a patient whose condition is in the physician's current realm of competence solely because the patient is seropositive; (2) the physician should render care with compassion and respect for human dignity;

(3) physicians unable to treat AIDS patients should refer them to appropriate sources of care; (4) physicians are obligated to respect the rights of privacy and confidentiality of AIDS patients; (5) physicians should urge AIDS patients to cease endangering others; if pursuasion fails, authorities should be notified; and if such notification does not result in proper action, physicians should notify endangered parties; (6) physicians who are seropositive should not engage in activities that may transmit the disease, and should consult with colleagues about safe activities.

Because of a failure to respond, one member was sanctioned by the Council this year, and this report will constitute public disclosure of that censure. A physician member, E. Gary Hogan, MD, did not fully and completely respond to questions issued by the Council following its initial investigation of a complaint, and censure was voted.

While the Council sees its responsibility as arbitrating complaints, in some instances matters must be referred to the Board of Medical Licensure. The Medical License Act, KRS 311, requires that any action taken by the Judicial Council and other stipulated organizations against member physicians must be reported to the Licensure Board. In one particular case, the Council referred to the Licensure Board a matter involving prescribing practices, as intense sanction was felt to be appropriate. In another case, where disagreements had arisen between two physicians that did not relate directly to medical practice but had evolved into legal proceedings, the issue was referred to the Licensure Board.

A number of patient complaints were received, some of which are still pending investigation and action. These ran the gamut from charges of refusal to treat, to alleged unfair hospital advertising and instances of questionable physician ethical behavior.

As medical practice changes due to the variety of economic and social pressures confronting it, all physicians are urged to keep uppermost the tradition of patient welfare as the major priority. The Council's efforts would have been diminished without the help of individual members and, in particular, the help of the KMA Trustees, who aid in initial investigations of complaints and in other situations. Any member is urged to solicit opinions from the Council or propose questions, and we sincerely appreciate the opportunity to serve the Association.

Harold L. Bushey, MD
Chairman

Report of the Rural Kentucky Medical Scholarship Fund, Inc.

The need for the Rural Kentucky Medical Scholarship Fund, Inc. becomes increasingly more important each year. According to a recent article published by the AMA, the number of rural physicians in this country could drop by as much as 25% in the next five years, even though in a recent survey, most small town doctors say they are satisfied with their practices. This decline would exacerbate current shortages of physicians in sparsely populated areas, leaving a significant part of the country's rural population without access to medical care.

For the school term 1988-89, RKMSF loans have been increased to $7,500, and the interest rate is 4.25%. Eleven new applicants were interviewed, and nine were approved for financial assistance. Eight renewal requests were received.

Four recipients are entering Family Practice residencies, one is entering an OB/GYN residency, and one is entering an Internal Medicine residency. Fourteen recipients are currently enrolled in primary care programs. Eight recipients are entering practice in 1988. Eleven recipients received forgiveness for loans in 1987-88.

The Fund is optimistic that the Establish Practice Grant Program will aid in resolving the maldistribution of physicians. This is a pilot program, which will place two physicians a year in a critical county in the state. In return, these physicians will receive a substantial sum of money over a period of four years to defray educational expenses.

In the past, the Fund's success has been based on the dedication of the members of the Board of Directors and the continued assistance and support of the Kentucky Medical Association.

Carolyn H. McKinley, MD
President

Report of the Membership Committee

The Membership Committee, although not formally meeting this year, participated in and directed a number of activities toward the recruitment and retention of practicing physicians, residents, and medical students.

Membership continues to grow and we are pleased to report that the Association again reached an all-time high in 1987, with 5,292 members, representing a 3% increase over 1986 figures. Although recruitment efforts resulted in the addition of 490 new members in 1987, the Association lost 296 Active members (compared with a loss of 223 in 1986) as:

66 — Changed from Active to Life
94 — Moved out of state
9 — Died
1 — Became ineligible due to Licensure Board action
126 — Did not renew for 1987

These figures confirm our position that membership development must be an ongoing effort of the Association and that we must strive through every means possible to retain current members and convince our nonmember colleagues to join.

Recruitment activities for 1988 have included statewide and targeted mail campaigns, membership phonathons, and

various promotional efforts. In addition to our ongoing programs of contacting newly licensed physicians and those who have recently moved to Kentucky to practice, a total of 14 separate mailings were sent to various segments of the nonmember population.

Beginning in the fall of 1987, members of the KMA Board of Trustees sent personal letters to nonmembers in their Districts. The Committee wishes to particularly thank Doctors Albert Joslin, J. Nicholas Terhune, Jerry Martin, and William Mitchell for their help in the Second, Third, Sixth, and Eleventh Districts, respectively.

In December, specialty group leaders in the state were asked to contact KMA nonmembers within their particular specialties. We appreciate the letters written on behalf of KMA by Doctors Larry Griffin (Obstetrics-Gynecology), C. Dale Brown (Radiology), and Charles Smith, Jr. (Internal Medicine). These efforts resulted in a number of new members for the Association as well as an increased interest in the individual specialty societies.

Nonmembers, aged 40 and under, were the focus of a mail campaign spearheaded by Donald Swikert, MD, as a part of the AMA Young Physician Outreach Program held in February and March. Because of the number of new members generated from this activity, Doctor Swikert was recognized by the AMA at the Young Physicians Section Annual Meeting in Chicago in June as one of the top recruiters in the nation. The Committee is proud of the work and dedication that Doctor Swikert has exhibited on behalf of membership recruitment and we congratulate him on this award.

An analysis of our recruitment plan indicates that direct mail accounts for the highest number of responses, but the Committee still feels strongly that personal contacts and other promotions serve to augment the overall program and result in a higher retention rate of new members. With that in mind, the KMA Executive Committee and several members of the KMA and Jefferson County Medical Society Membership Committees participated in recruitment phonathons during April.

For the fourth year, the Executive Committee conducted a Nonrenewal Phonathon and called members who had not yet rejoined for 1988. To date, 70% of those indicating they planned to renew have done so. Participating in this year's phonathon were Doctors Donald Barton, Bob DeWeese, Nelson Rue, S. Randolph Scheen, William Monnig, and John Noonan.

Two Nonmember Phonathons were held for the first time this year on April 13 and April 27. Over 135 personal contacts were made during those sessions. Ninety-seven of that number, or 72%, indicated an interest in joining. The results to date are encouraging and reinforce our belief that peer-to-peer recruitment is one of the most effective tools in membership development. In addition to myself, those participating were Charles Allnutt, MD; Irene Roeckel, MD; M. S. Viji, MD; Syed Nawab, MD; Gorden McMurry, MD; and John Whitt, MD.

The Committee is currently working on the production of a membership videotape to be distributed to nonmember physicians in Kentucky during the summer and fall of 1988. Undertaken as a pilot project with the AMA, the videotape is being produced by The Preston Group, a Lexington public relations firm. A number of KMA members, representing various specialties, types of practice, and locations, provided testimonials in the videotape on the importance of organized medicine. We want to thank those who participated in the filming for their time commitment to this project: Nick Dedman, MD; Greg Cooper, MD; Bill Bacon, MD; Judith Joyce, MD; Donald Swikert, MD; Marjorie Fitzgerald, MD; William DeVries, MD; and Larry Griffin, MD.

We continue to be encouraged by the number of residents and medical students who belong to organized medicine. Currently, In-Training and Student memberships account for 16% of all KMA members. AImost 50 new residents were recruited during the Housestaff Orientations held June 28 at the University of Kentucky and June 30 at the University of Louisville. The Committee wishes to thank Gary Earle, MD, Lexington, and Larry Griffin, MD, Louisville, for representing KMA and their county medical societies at this year's Orientations.

Student membership also continues to grow, and the U of K and U of L Chapters of the KMA Medical Student Sections were recently recognized by the AMA for their outstanding achievements in membership recruitment. Currently, 76% of the students at U of L and 49% of the U of K students belong to KMA.

A number of practice management workshops were sponsored during 1987-88 by the Membership Committee in such areas as employee relations/contract review, starting a medical practice, third-party reimbursement and coding, and planning for retirement. All have received high evaluations, providing a worthwhile benefit to the more than 200 physicians, spouses, and office personnel who attended the workshops. The Committee continues to look for member services which will benefit the membership and welcomes suggestions and input from KMA members.

As has been our custom in this annual report, the membership status as of June 30, 1988, follows:

Membership Category	# as of 6/30/88	# as of 12/31/87
Active	3,533	3,566
In-Training	255	266
Total Dues-Paying	4,048	4,086
Total KMA All Categories	4,989	5,292

On behalf of the Committee, we wish to thank those who have worked in any way to encourage and strengthen the membership of this Association. One nonmember physician told us during one of the phonathons, "No one ever asked me to join." Don't let anyone use that excuse again. I hope

you will encourage physicians in your community to support the Association. Your personal contact can make a difference.

Harold D. Haller, Sr, MD
Chairman

Report of the Committee on Constitution and Bylaws

The purpose of your Committee on Constitution and Bylaws is to implement changes that have been proposed in KMA's Constitution and Bylaws. Since no proposals for change were presented during this Associational year, the Committee found it unnecessary to meet.

We stand ready to be of assistance whenever matters warrant our attention.

Danny M. Clark, MD
Acting Chairman

Report of the McDowell House Board of Managers

In an unusual bequest this year, a historic, magnificent, approximately 550 acre central Kentucky horse farm is to be bequeathed the KMA McDowell House Board of Managers upon the demise of the two present owners. In response to this future legacy, papers have been drawn and filed, establishing a new KMA non-profit McDowell Foundation, which will receive this farm and appurtenances in the future. Plans have been formulated for this new Foundation to eventually oversee the present McDowell House Board and its management of the McDowell House. The new Foundation Board has been established and consists of the KMA Quick Action Committee plus three members selected from the present McDowell House Board.

Last year, improvements and restoration costs to the McDowell House led to expenditure of $4,595 above the 1987-88 budget of $39,900. This deficit was covered by withdrawal of endowment funds. Our planned 1988-89 budget will be almost $40,000. At present, our endowment fund investment grows at about $10,000 yearly, and returns from the fund constitute a significant part of our operating expenses. Continued support by the KMA Auxiliary, various state and national physician organizations, and "Friends of McDowell House" serves to provide the additional funds to maintain this shrine in prime condition.

We are saddened this year by the significant loss of two of our most active and respected Board members: Branham B. Baughman, MD, an outstanding Frankfort surgeon, and Enos Swain, Danville's leading newsman. Their contributions were many and their loyalty to the preservation and operation of the McDowell House was of the highest order.

David W. Kinnaird, MD
Chairman

Report of the Medical Student Section

The KMA Medical Student Section has had one of its most active years since its establishment. A report from each of the Chapters follows:

University of Louisville

The academic year of 1987-88 saw a remarkable growth in student interest in the issues of organized medicine. With the establishment of the AIDS Education Program and the intense recruitment of students through the Medical Student Outreach Program, the U of L Chapter of the KMA-MSS is now one of the most active organizations on campus and has an active membership of 382, representing 76% of students.

During the past year, the Section was represented at the April meeting of the KMA Board of Trustees and has sent Delegates, Alternate Delegates, and members to the Annual and Interim Meetings of the AMA-MSS, as well as to the Annual Meeting of the KMA House of Delegates. Students have also served on and attended meetings of various committees of the KMA.

The U of L Chapter met on September 3 to elect officers and discuss issues of concern to medical students. Among items acted upon were the dissolution of Chapter dues and changes in Chapter Bylaws to coincide with the KMA-MSS Constitution and Bylaws. In addition, a petition to the Board of Directors of Kentucky Telco Credit Union resulted in an increase in credit card limits for students.

As part of our membership recruitment efforts, Harold Haller, MD, spoke to the freshman class concerning the purposes and advantages of organized medicine. As a result of our increase in membership, the Chapter received the maximum award from the AMA Medical Student Outreach Program of $1,600, and was recognized at the AMA-MSS Interim Meeting in December and at the KMA April Board meeting for its efforts.

Other activities included the initiation of a quarterly newsletter and a letter-writing campaign by several students during the recent Kentucky General Assembly. Chapter officers and Governing Council members for 1988-89 were elected during the May meeting, and I am pleased to report that Todd Pesavento is Chapter President for this academic year. The establishment of the KMA-MSS Governing Council marks a new height of cooperation and involvement among students in organized medicine.

On behalf of the University of Louisville Chapter of the KMA-MSS, I would like to thank the members and staff of the Kentucky Medical Association for their continued support. We truly appreciate the opportunity to be involved in issues which affect our future.

University of Kentucky

The KMA-MSS Chapter at U of K experienced a very

successful year with renewed enthusiasm from the students and full support from the Acting Dean and the Office of Education.

Early in the academic year, Acting Dean Emery Wilson, MD, spoke at a meeting of the MSS on the importance of organized medicine. This effort, along with peer-to-peer recruitment in conjunction with the AMA-MSS Outreach Program, resulted in tremendous growth in membership. Our total active membership of the UK-KMA-MSS is 184, representing 50% of the students. This represents a 35% increase in membership over 1986-87.

The 77 new members gained through the Outreach Program made us eligible for the maximum award ($1,600) from the American Medical Association. Because of this effort and the continuing financial support of the KMA, we were able to send four student representatives to both the Interim and Annual Meetings of the AMA-MSS. Our Chapter was recognized for its recruitment efforts at the AMA-MSS Interim Meeting in December, at the Fayette County Medical Society meeting in March, and at the KMA Board of Trustees meeting in April.

During the past year, the Chapter at U of K has been active in several areas. We have established an AIDS education program which, hopefully, will serve the schools in Fayette County and the surrounding counties. We also participated in a drive for organ donor card signing which produced 110 signatures in a week. We had a very active letter-writing campaign during the Kentucky General Assembly and have instituted a quarterly newsletter to inform students in a timely manner of upcoming events and progress on past topics of discussion. Student members have also served on several KMA committees this past year and our Chapter has been represented at the meetings of the KMA Board. We look forward to participating in this year's KMA Annual Meeting in Lexington.

As a Chapter, we have asked Kentucky Telco Credit Union to study the feasibility of a loan program for medical students that would be similar to the GSL program.

Chapter officers for 1988-89 were elected in April, and Paul Austin will serve as President for the coming year. Our future agenda includes a study of the Chapter Constitution and Bylaws and working more closely with the MSS Chapter at U of L to form a statewide Governing Council.

The UK-KMA-MSS Chapter appreciates the support of the members and staff of KMA and wishes to thank them for the opportunity to shape the future of medicine.

Terry Cleaver
President, UL-KMA-MSS
Baretta Casey
President, UK-KMA-MSS

Report of the Resident Physicians Section

The KMA Resident Physicians Section, established by the House in 1984 to serve as a forum for discussion and as a voice for Kentucky residents, is governed by a Council composed of representatives from the four residency programs in the state. The KMA-RPS Governing Council met on two occasions during the past year to discuss issues of concern to residents.

Through representation at the state and national levels, the KMA-RPS was influential this year in effecting policy on access to tobacco by children and hospital security. The KMA House adopted RPS Resolutions at the 1987 Annual Meeting concerning these matters and referred a third Resolution concerning resident on-call schedules to the Physician Manpower Committee for further study.

The Section sponsored a seminar at the University of Kentucky on October 2 on "Contract Analysis." Through the efforts of Council member Kimberly Cornelius, MD, who coordinated arrangements for the program, over 40 housestaff physicians attended this noon conference. It is hoped that similar programs can be scheduled at the other residency programs on socioeconomic and practice management topics.

Kentucky's Delegate to the AMA-RPS, Vaughn Payne, MD, attended the Interim and Annual Meetings of the national Section this year and was privileged to serve on a Reference Committee at the AMA-RPS Annual Meeting in June. Reports from these meetings generated discussion by the Council on topics such as resident working hours, the impact of AIDS on residency training, and maternity/paternity leave policy of residency programs.

In addition to having voting Delegates at the AMA and KMA meetings, the RPS has been represented this year at meetings of the KMA Board of Trustees and has members serving on more than 20 committees of the Association. At the present time, almost 40% of the resident population in Kentucky are In-Training members of KMA. We are grateful to those programs which encourage their residents to participate in organized medicine.

On behalf of the KMA-RPS Governing Council, I would like to express my gratitude to the House of Delegates and to individual members of KMA for their support and encouragement. As resident physicians, we appreciate the opportunity to have a voice in issues affecting our future practice of medicine.

Forrest Hanke, MD
KMA-RPS President

Report of the Young Physicians Steering Committee

Addendum to the Report of the Chairman, Board of Trustees

An ad hoc committee on young physicians was chartered by the AMA Board of Trustees in September 1984 to study

the special concerns of young physicians and to determine ways in which organized medicine can be more responsive to such concerns. The committee was requested to provide specific recommendations which would increase the involvement of young physicians in all levels of organized medicine. In April 1986 the ad hoc committee on young physicians presented a final report with recommendations to the AMA Board of Trustees. The ad hoc committee made three specific recommendations:

1. The AMA establish an assembly of young physicians comprised of one Delegate and one Alternate Delegate from each state; that the assembly be granted one Delegate with voting privileges in the AMA House of Delegates; and that the meeting of the assembly be held in conjunction with the meeting of the AMA House of Delegates.

2. The AMA strongly encourage and assist each state in establishing a state-level assembly of young physicians as a means of strengthening the direct and meaningful participation of young physicians throughout the federation.

3. The AMA take the lead through its appointment process; while doing so, strongly encourage state, county, and medical specialty societies to actively seek out and appoint qualified young physicians to appropriate council and committee leadership positions. These recommendations were based on some very important considerations. Young physicians continue to increase in number. Of the approximately 400,000 active physicians in this country, 210,000 are young physicians; ie, under forty years of age. This represents 52.6% of the active physician population. Challenges faced by organized medicine are great. Twenty-four and four-tenths percent, or 51,000, of these young physicians are members of the AMA. Over 38,000 of these young physicians are women, constituting 18.3% of the young physician group. Young physicians, when considered as a group, represent a sizable constituency of the medical profession.

Individual young physicians are facing increased economic pressures. These pressures include increasing medical school debts, increasing and prohibitive costs of establishing and building a practice, increasing liability coverage costs, and heightened competition as a result of an increasing number of physicians. Prior to 1986, only one Delegate to the AMA House of Delegates under the age of 40 was a practicing young physician. Most of the young physicians contacted through surveys expressed a lack of personal identity with, or felt isolated from, organized medicine. At the June 1986 AMA Annual Meeting, the House of Delegates approved the assembly and the Board of Trustees appointed a steering committee to plan for the inaugural meeting which was held in December 1986. As a result, the AMA Young Physicians Section was implemented in January 1987.

In the state of Kentucky there are 1,981 physicians under the age of 40. Of these, 1,322 are KMA active members representing 39% of KMA active members and 67% of the total physicians of this age group.

For the past two years, I have served as Kentucky's Delegate to the Young Physicians Section of the American Medical Association. Based on my experience with the KMA, there is opportunity and support for young physicians to become actively involved in the Association's decision-making process, and I personally feel that a special section is not in the best interest of the young physicians of our state because it would only tend to isolate the young physicians into a section and thereby give them less representation at their state level.

It was felt that a far better way for the KMA to accomplish the previously outlined goals would be to provide a committee setting where one-day conferences could be conducted for the young physicians of the state with emphasis on providing young physicians with needed information, help, and services. The KMA, as well as the AMA, needs to offer a forum in which young physicians could get together and discuss their concerns and issues that specifically apply to them. This would also allow for identification of those young physicians throughout the state interested in being appointed to positions of participation and leadership through committees and other activities of the Association.

The KMA Board of Trustees approved the appointment of a Young Physicians Steering Committee, and this Committee, comprised of nine physicians aged 40 or under, met for the first time on February 12, 1988.

In follow up to discussions regarding holding a one-day seminar for young physicians to discuss issues of concern to them, plans have been made for such a seminar to be held Saturday, November 12, 1988, at the Brown Hotel in Louisville. The seminar will feature presentations on issues of interest to both young physicians and their spouses, such as the AMA Young Physicians Section; contracts and partnership agreements; financial planning; dealing with stress; and participation in the legislative process. A children's program and options for the afternoon and evening will also be offered.

A Delegate and Alternate Delegate attend the Annual and Interim AMA-YPS Section meetings, and it is hopeful that young physicians who are not currently involved in organized medicine can represent KMA at these meetings.

With the establishment of the KMA Young Physicians Steering Committee, the Association will be able to better identify issues of interest to young physicians, discuss ways those issues might be addressed, and take appropriate action.

Donald J. Swikert, MD
Chairman

END OF CONSENT CALENDAR ITEMS

Report of the Physician-Attorney Liaison Committee

The Physician-Attorney Liaison Committee met on two occasions during the Associational year. At the first meeting, Committee members, along with KMA-KBA Officers, openly discussed the liability crisis. Although no compromise or agreement took place, the meeting provided an opportunity to air our grievances with the present legal system. We learned that the Bar Association was in the process of starting its own liability insurance company as a result of the liability crisis experienced in its members' practices.

At the second meeting, charges for copying medical records and deposition fees were the major agenda items. A joint statement is being prepared by Co-Chairman John T. Ballantine of the Kentucky Bar Association and myself concerning this matter. The Committee believes that most, if not all, disagreements stem from lack of frequent and open discussion between lawyers and physicians. The Committee believes that, at present, the medical records copying and deposition charges are not a widespread problem. The joint statement will be submitted to the KMA *Journal* Editors in the near future. The Committee urges physicians to read the "Interprofessional Code" and comply with those provisions jointly defined and agreed to by the professions.

In some states, prearranged and scheduled depositions, in accordance with an agreement jointly issued by the Bar and Medical Associations, have ceased to exist. Many attorneys simply subpoena the physician, refusing to take into account patient schedules or personal inconveniences. Of greater concern is the possibility that the Bar Association will support an open medical records law that exists in many states. We are aware that some trial lawyers and consumer groups are pursuing legislation to permit direct access to medical records.

During the meeting, the Committee recommended that a set charge for medical records not be established. However, if the problem continues, the enactment of a fee schedule similar to the Workers' Compensation schedule may be inevitable. A movement already exists within the legal profession and consumer groups to establish a fee schedule. We need to be alert to this situation and the potential problem a few physicians can impose on the majority.

The Committee discussed the periodic publishing of the "Interprofessional Code." However, previous recommendations which the House of Delegates adopted in 1987 directed that the "Interprofessional Code" be printed in the KMA *Journal* every other year.

In 1988 I retired from practice. This Committee should be comprised of active, practicing physicians and, therefore, with this Report I tender my resignation. It has been a pleasure to serve KMA and work on a Committee which labors to alleviate problems between two noble professions. I wish to thank members of the Committee, both physicians and attorneys, for the kindness and assistance they have shown to me over the years.

Thomas M. Marshall, MD
Co-Chairman

Recommendations, Reference Committee No. 6:

Reference Committee No. 6 considered the Report of the Physician-Attorney Liaison Committee and commends Doctor Thomas Marshall for his many years of dedicated service to improving relationships between physicians and attorneys. Reference Committee No. 6 recommends that the Report of the Physician-Attorney Liaison Committee be filed.

Resolution J

ACLS and BCLS Certification for Residents
Resident Physician Section

WHEREAS, of the 1.5 million people in the United States who sustained a myocardial infarction in 1987, 190,000 died after reaching the hospital, and

WHEREAS, all housestaff physicians may have occasion to perform Basic or Advanced Cardiopulmonary Life Support in the hospital, now therefore be it

RESOLVED, that KMA encourage residency programs in the state to provide ACLS and BCLS certification for all residents, regardless of specialty.

Recommendations, Reference Committee No. 6:

Reference Committee No. 6 next considered Resolution J, ACLS and BCLS Certification for Residents, submitted by the Resident Physicians Section of KMA, and recommends that it be adopted.

Mr. Speaker, Reference Committee No. 6 recommends the adoption of the Report of Reference Committee No. 6 as a whole.

Mr. Speaker, I would like to personally thank the members of the Reference Committee for their help on the issues discussed and the formulation of this report. Members of the Committee were: John J. Jefferies, MD, Owensboro; Carol S. Milburn, MD, Crestview Hills; William C. Nash, MD, Elizabethtown; and Andrew R. Pulito, MD, Lexington. I would also like to thank Diane Maxey for her assistance in preparing this report.

Reference Committee No. 6

Harold D. Haller, Sr, MD, Louisville, Chairman
John J. Jefferies, MD, Owensboro
Carol S. Milburn, MD, Crestview Hills
William C. Nash, MD, Elizabethtown
Andrew R. Pulito, MD, Lexington

Election of Officers

Scott B. Scutchfield, MD, Danville, Chairman of the Nominating Committee, presented the slate of nominees for general Officers, and each was elected by acclamation.

President-Elect	Nelson B. Rue, MD Bowling Green
Vice President	Russell L. Travis, MD Lexington

Doctor Scutchfield then presented the slate for Delegates to the AMA:

Delegate to the AMA (January 1, 1989 to December 31, 1990 — two slots)	Kenneth P. Crawford, MD Louisville Ardis D. Hoven, MD Lexington Wally O. Montgomery, MD Paducah

Following a written ballot, Doctor Scutchfield announced that Doctors Crawford and Montgomery would fill the two AMA Delegate positions.

The slate for Alternate Delegates to the AMA was then presented:

Alternate Delegate to the AMA (January 1, 1989 to December 31, 1990 — two slots)	Peter P. Bosomworth, MD Lexington Robert R. Goodin, MD Louisville Donald J. Swikert, MD Florence Ardis D. Hoven, MD Lexington (nominated from the floor)

The Speaker informed the Delegates that Chapter IV, Section 1, of the KMA Bylaws states that, "Delegates to the AMA and their Alternates shall be elected from the state at large for terms of two years, with the provision that no more than one Delegate and no more than one Alternate Delegate shall be elected from one component society," and that it would be necessary to hold a run-off election between the two candidates from Fayette County. The results of that election produced the following slate for election of two Alternate Delegates to the AMA for two-year terms, beginning January 1, 1989, and ending December 31, 1990:

Robert R. Goodin, MD, Louisville
Ardis D. Hoven, MD, Lexington
Donald J. Swikert, MD, Florence

Following a written ballot, Doctor Scutchfield announced that Doctors Goodin and Hoven would fill the two AMA Alternate Delegate positions.

It was noted that Doctor Montgomery's election as a Delegate to the AMA would create a vacancy in the position he held as AMA Alternate Delegate. Donald J. Swikert, MD, Florence, was nominated from the floor to fill the unexpired term of AMA Alternate Delegate (January 1, 1989 to December 31, 1989), and was elected by acclamation.

Doctor Scutchfield then submitted the following nominations for the offices of Trustees and Alternate Trustees on behalf of the Trustee District nominating committees:

2nd District Trustee	John W. McClellan, MD Henderson
2nd District Alternate	Christopher R. McCoy, MD Owensboro
7th District Trustee	Cecil D. Martin, MD Carrollton
7th District Alternate	William P. McElwain, MD Lawrenceburg
9th District Trustee	Kelly G. Moss, MD Maysville
9th District Alternate	L. Frank McBrayer, MD Georgetown
10th District Trustee	Preston P. Nunnelley, MD Lexington
10th District Alternate	Thomas K. Slabaugh, MD Lexington
13th District Trustee	Charles T. Watson, MD Ashland
13th District Alternate	Bruce M. Stapleton, MD Ashland

The new President-Elect, Nelson B. Rue, MD, and Mrs. Rue were escorted to the podium by Past Presidents Wally O. Montgomery, MD, and Paul J. Parks, MD.

Election of 1989 Nominating Committee

The following physicians were elected by the House of Delegates to serve as the 1989 KMA Nominating Committee:

Ronald E. Waldridge, MD, Shelbyville, Chairman
Gregory J. Sherry, MD, Somerset
Bruce M. Stapleton, MD, Ashland
Gary R. Wallace, MD, Lexington

Doctor Campbell adjourned the 1988 Session of the KMA House of Delegates at 8:30 PM.

1988 CONSTITUTION AND BYLAWS OF THE KENTUCKY MEDICAL ASSOCIATION

CONSTITUTION

Article I. Name of the Association
Article II. Purpose of the Association
Article III. Component Societies
Article IV. Composition and Meetings of the Association
Article V. Officers
Article VI. House of Delegates
Article VII. Districts, Sections and District Societies
Article VIII. Board of Trustees
Article IX. Funds and Expenses
Article X. Referendum
Article XI. The Seal
Article XII. Amendments
Article XIII. Definitions

Article I. Name of Association

The name and title of this organization shall be the Kentucky Medical Association.

Article II. Purpose of the Association

The purpose of the Association shall be to federate and bring into compact organization the entire medical profession of the State of Kentucky and to unite with similar associations in other states to form the American Medical Association, with a view to the extension of medical knowledge; the advancement of medical science and charity; the evaluation of the standards of medical education; the enactment and enforcement of just medical laws; the promotion of friendly intercourse among physicians and the guarding and fostering of their material interests; the protection of the members thereof against unjust assaults upon their professional care, skill or integrity; and to the enlightenment and direction of public opinion in regard to the great problems of state medicine so that the profession shall become more capable and honorable within itself and more useful to the public in the prevention and cure of disease and in prolonging and adding comfort to life.

Article III. Component Societies

Component societies shall consist of those medical societies which hold charters from this Association.

Article IV. Composition and Meetings of the Association

The Association shall consist of the members of the component societies, but the House of Delegates shall have authority to adopt such bylaws regulating the admission and classification of members as it may deem advisable. The Association shall hold an Annual Meeting and such Special Meetings as may be called pursuant to the bylaws.

Article V. Officers

Section 1. The officers of this Association shall be a President, a President-Elect, a Vice-President, a Secretary-Treasurer, a Speaker and Vice-Speaker of the House of Delegates, a Trustee and an Alternate Trustee from each district that may be established; and such other officers as may be provided for in the Bylaws.

Section 2. The eligibility, duties and terms of office of all officers of the Association shall be as prescribed in the Bylaws.

Section 3. All officers shall serve until their successors have been elected and installed.

Section 4. All officers shall be elected by the House of Delegates at its Regular Session and shall take office on the last day of the Annual Meeting.

Article VI. House of Delegates

Section 1. The House of Delegates shall be the legislative body of the Association and shall have power, by a two-thirds vote of all the delegates present at that session, to adopt bylaws to carry out the provisions of this Constitution and to provide for the government of the Association in any other manner not inconsistent with this Constitution. It shall meet in Regular Session, annually during the Annual Meeting of the Association, and may be called into Special Session under such conditions as may be prescribed in the bylaws.

Section 2. Delegates shall be members of and elected by component county societies in such a manner as may be provided in the Bylaws. Officers of the Association, Delegates and Alternate Delegates of the American Medical Association and five immediate Past Presidents shall be the ex-officio members of the House of Delegates and entitled to vote. All other Past Presidents and Vice-Presidents and Past Chairmen of the Board of Trustees shall be ex-officio members of the House. They shall have the right to speak and debate on the floor of the House but shall not have the right to make a motion, introduce business or an amendment, or vote.

Section 3. The House of Delegates shall elect a Speaker and a Vice-Speaker, one of whom shall preside during the meetings of the House of Delegates. The presiding officer shall not be entitled to a vote except in the event of a tie.

Section 4. The House of Delegates shall be the final judge as to the qualification of its members.

Article VII. Districts, Sections and District Societies

The House of Delegates shall divide the state into Districts composed of one or more counties, for administrative purposes. It may also provide for a division of the scientific work of the Association into appropriate Sections, and for the organization of such District Societies, composed exclusively of members of component societies, as will promote the best interests of the profession.

Article VIII. Board of Trustees

The House of Delegates shall make provision in the bylaws for a Board of Trustees composed of one Trustee from each District and such of the other officers of the Association as the House may deem appropriate, which shall be charged with the general direction of the Association's affairs during the interim between meetings of the House. The House may delegate such powers to the Board of Trustees as are not specifically required by this Constitution to be exercised by the House, and may limit the Board's powers to such extent as it may determine to be necessary or desirable, provided, however, that in no event shall the Board of Trustees have power to commit the Association to any course of action which is contrary to or at variance with any policy established by the House of Delegates.

Article IX. Funds and Expenses

The House of Delegates shall provide funds for meeting the expenses of the Association by such methods and from such sources as it may select. Funds may be appropriated by the House of Delegates to defray the expenses of the annual session, for publications, and for such other purposes as will promote the welfare of the Association and the profession.

Article X. Referendum

The membership of the Association, by written petition signed by not less than 10% of the active membership, may obtain a referendum on any question pending before the House of Delegates. The Secretary-Treasurer, upon the presentation of such a petition to him shall cause the question to be submitted to the active membership by mail, and if a majority of the active members shall signify its approval or disapproval of a certain policy or course of action with respect to the question thus submitted, the will of the majority shall determine the question and shall be binding upon the House of Delegates and the Association upon certification of the result of the vote by the Secretary-Treasurer to the President and Board of Trustees.

Article XI. The Seal

The Association shall have a common Seal with power to break, change or renew the same at pleasure.

Article XII. Amendments

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the delegates registered at the Regular Session, provided

that such amendment shall have been presented in open meeting at the previous regular session, and that it shall have been sent officially to each component county society at least two months before the session at which final action is to be taken.

Article XIII. Definitions

Whenever used in this Constitution, the Articles of Incorporation or the Bylaws—

(a) "County society," "component county society," or "component medical society" means "component society."

(b) "Annual Meeting" means the annual three-day meeting of the Association.

(c) "Scientific Sessions" mean those sessions during the Annual Meeting at which scientific subjects are programmed and discussed.

(d) "Regular Session" means the regular session of the House of Delegates which is held during the Annual Meeting.

(e) "Special Session" means a special, called meeting or session of the House of Delegates.

BYLAWS

Chapter I. Membership
Chapter II. Annual and Special Meetings of the Association
Chapter III. The House of Delegates
Chapter IV. Election of Officers
Chapter V. Duties of Officers
Chapter VI. Board of Trustees
Chapter VII. Discipline-The Judicial Council
Chapter VIII. Standing Committees and Councils
Chapter IX. Assessments and Expenditures
Chapter X. Rules of Conduct
Chapter XI. Rules of Order
Chapter XII. County Societies
Chapter XIII. Amendments

CHAPTER I. MEMBERSHIP

Section 1. Membership in this Association shall be coterminous with membership in a component county society. No physician shall be eligible for membership in this Association unless he is a member, in good standing of a component society, nor may he maintain membership in a component county society unless he is a member, in good standing of this Association.

When a physician who meets the qualifications hereinafter set forth, is certified to the Secretary-Treasurer as a member in good standing of a component society, properly classified as to type of membership, and when the dues pertaining to his membership classification have been received by the Secretary-Treasurer of the Association, the name of the member shall be included in the official roster of the Association and he shall be entitled to all the privileges of his class of membership. Provided, however, that members in good standing from other state societies may, if admitted to membership by a component society, be accepted by KMA for membership without paying dues for the remainder of the calendar year in which the transfer is made. Provided further, that the Board of Trustees shall have power, upon written application, approved annually by the county society of which the applicant is a member, to excuse any member from the payment of dues because of financial hardship. And provided further, that the Judicial Council, after a hearing, shall have power to condition membership in this Association upon the physician's agreement to limit the scope of his practice in any manner reasonably calculated to protect the public from the adverse effects of any demonstrated frailty or disability of said member.

Section 2. Membership in the Association shall be divided into nine classes, to wit: Active, Life, In-Training, Associate, Inactive, Student, Service, Honorary and Special.

(a) Active Members. The active membership of the Association shall consist of the active members of the various component medical societies. To be eligible for active membership in any component society, the applicant must be a physician who holds an unrestricted or limited license to practice medicine and surgery in this state, and who is of good moral, ethical and professional standing. Nothing contained herein shall prevent a component society from requiring new members to occupy provisional status for a reasonable time after their admittance to membership under any classification.

(b) Life Members. Component societies may elect as a life-member any doctor of medicine or osteopathy who has served his profession with distinction and who has either reached the age of 70 or has retired from active practice. Life members shall have the right to vote and be entitled to the benefits of Chapter VI, Section 8 of these Bylaws, but shall not pay dues. They shall receive *The Journal* and other publications of the Association.

(c) Resident Physicians Section. Doctors of medicine or osteopathy who have complied with all pertinent regulations of the Kentucky Board of Medical Licensure and who are serving in AMA approved training programs in Kentucky shall be eligible for membership in the Resident Physicians Section of the Kentucky Medical Association. The Resident Physicians Section shall be governed by its own Constitution and Bylaws, which shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. In-Training members in good standing shall have the right to vote and receive all publications of the Association. In-Training members shall not be counted in determining the number of delegates to which their county society is entitled in the House of Delegates. The Resident Physicians Section will be represented in the KMA House of Delegates by one voting representative elected by the Governing Council of the Resident Physicians Section.

(d) Associate Members. The associate membership of the Association shall consist of the associate members of the various component medical societies. To be eligible for associate membership in any component society, the applicant must qualify under one or more of the following groups:

(1) Medical officers of the United States Army, Navy, Air Force, Veterans Administration, Public Health Service, or other federal governmental service while on duty in the State, but shall not be deemed to include physicians employed on a full-time basis by the Veterans Administration.

(2) Dentists may be invited to become Associate members.

(3) Physicians residing and/or practicing in communities bordering Kentucky who are active members of their home state and county society and who wish to become members of KMA on an other than active basis may become Associate Members.

Associate members shall not have the right to vote nor to hold office, but shall receive *The Journal* and other publications of the Association.

(e) Inactive Members. The inactive membership of the Association shall consist of the inactive members of the various component county societies. Any doctor of medicine licensed to practice medicine in Kentucky who is not engaged in the practice of medicine but who is otherwise eligible for active membership in the Association may be admitted to inactive membership by any component county society. Inactive members shall not have the right to vote nor hold office, but shall receive *The Journal* and other publications of the Association.

(f) Student Members. Any student in an accredited medical school in Kentucky or any resident of Kentucky who is a student in an accredited medical school in the United States shall be eligible for membership in the Medical Student Section of the Kentucky Medical Association. This Medical Student Section shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. Membership shall be coincident with the academic enrollment of the student. Student members may not hold office in the State Association, but may be voting members of any State Association committee to which they are appointed. Student members may, however, hold office within the Student Section in accord with the provisions of that Section's Constitution and Bylaws. The Student Section will be represented in the KMA House of Delegates through one voting representative, a student member of the Kentucky Medical Association elected by the Student Section membership attending the University of Kentucky College of Medicine, and one voting representative, a student member of the Kentucky Medical Association elected by the Student Section membership attending the University of Louisville School of Medicine.

(g) Service Members. Members of the Association in good standing who enter military service and are ineligible for Association membership shall be classified as service members. Service Members shall not be required to pay dues. If a member in good standing enters service prior to April 1 and has paid his dues for that year, he shall receive all publications and other benefits applicable to his class of membership in the Association and shall owe no further dues until January 1 following his release. If a member in good standing enters service prior to April 1 without paying his dues for that year, he shall receive publications and other benefits but shall owe the dues applicable to his class of membership immediately following his release from active duty. Members whose dues have not been received by April 1 are not in good standing.

(h) Honorary Members. Any physician possessed of scientific attainments who is a member of a constituent state medical association and who has participated in the program of the scientific session and who is not a citizen of Kentucky may by unanimous vote of the House of Delegates be elected to honorary membership. Honorary members shall be entitled to the privileges of the floor in all scientific sessions.

(i) Special Members. Component societies may invite pharmacists, funeral directors, or other professional persons to become special members. Special members shall have no rights or obligations under these Bylaws, but may be accorded the privilege of attending and participating in the scientific meetings of the society, provided, however, that a registration fee may be required of special members who desire to attend the Annual Meeting of the Association.

Section 3. Hospital Medical Staff Section. There shall be a special section for hospital medical staff physicians who already hold membership in KMA. The Hospital Medical Staff Section (HMSS) shall be governed by its own Constitution and Bylaws, which Constitution and Bylaws shall not be in conflict with the Constitution, Bylaws and Board policies of the parent Kentucky Medical Association. Should any questions arise regarding the existence of a conflict, the KMA Board of Trustees shall be the final arbiter of such questions. The Hospital Medical Staff Section shall elect a Delegate and Alternate Delegate to the KMA House of Delegates. The Delegate to the KMA House of Delegates, or his Alternate as the case may be, shall be a voting member of the House and may present resolutions on behalf of the HMSS.

Section 4. Guests of Honor. Any distinguished physician not a resident of this State may become a guest of honor during any Annual Meeting upon invitation of the Board of Trustees and shall be accorded the privilege of participating in all of the scientific work of that meeting.

Section 5. No person who is finally convicted of a felony subsequent to September 26, 1968, shall be eligible for membership in this Association unless and until, upon proper application to the Judicial Council, it is determined that he is morally and ethically qualified. Except as provided in Chapter VII, Section 4 of these Bylaws, no person who is under sentence of suspension or expulsion from any component society of this Association shall be entitled to any of the rights or benefits of membership of this Association.

CHAPTER II. ANNUAL AND SPECIAL MEETINGS OF THE ASSOCIATION

Section 1. The Association shall hold its annual and special meetings at such times and places as may be determined by the House of Delegates.

Section 2. The Annual Meeting shall consist of one or more scientific sessions, at least two meetings of the House of Delegates, and such other gatherings as may be authorized by the Board of Trustees. Each scientific session shall be presided over by the President or in his absence or disability or at his request by the President-Elect or such officers as the Board of Trustees may direct. The entire time of the scientific sessions, as far as may be, shall be devoted to papers and discussions related to scientific medicine.

Section 3. The name of a physician upon the properly certified roster of members or list of delegates of a component society which has paid its annual assessment, shall be prima facie evidence of his right to register at any meeting of this Association.

Section 4. Each member in attendance at any meeting shall register indicating the component society of which he is a member. When his right to membership has been verified by reference to the roster of the society, he shall receive a badge which shall be evidence of his right to all privileges of membership at that meeting. No member or delegate shall take part in any of the proceedings of any meeting until he has complied with the provisions of this section.

CHAPTER III. THE HOUSE OF DELEGATES

Section 1. The House of Delegates shall meet in Regular Session at the time and place of the Annual Meeting, and shall, insofar as is practicable, fix its hours of meeting so as to give delegates an opportunity to attend the scientific sessions and other proceedings. Provided, however, that if the business interests of the Association and profession require, the Speaker, with the consent of the Board of Trustees, may convene the Regular Session in advance of the Annual Meeting, and the House may remain in session after the final adjournment thereof.

Section 2. The House may be called into Special Session by the President with the approval of the Board of Trustees, and a special session shall be called by the President on the written request of fifty duly elected delegates of the Association. The purpose of all special sessions shall be stated in the call, and all business transacted at any such special session shall be germane to the stated purpose.

Section 3. When a special session is called, the Secretary-Treasurer shall mail a notice of the time, place, and purpose of such meeting to the last known address of each delegate at least ten days before such session.

Section 4. The Speaker shall, by virtue of his office, be responsible for making all arrangements for all sessions, regular or special, of the House.

Section 5. The members of the House of Delegates shall be elected by the various component societies in the manner prescribed in Chapter XII of these Bylaws.

Section 6. In the event a component society is not represented at any meeting of the House, the Speaker shall consult with any officer of the component society who is in attendance and, with the approval of the Credentials Committee, may appoint any active member of such component society who is in attendance, as its alternate delegate. If no officer of such society is present, the Speaker may make the appointment without consultation, but with the approval of the Credentials Committee. All such appointments shall also be subject to the approval of the House.

Section 7. Forty percent of the qualified delegates, as defined by Article VI of the constitution, shall constitute a quorum and all of the meetings of the House shall be open to the members of the Association. The House shall have the right to go into executive session whenever in its judgment such action is indicated; except that active members of the Association shall have the right to attend all executive sessions.

Section 8. Each resolution introduced into the House shall be in writing and signed by the author and presented to the Secretary-Treasurer following its introduction. If the author presenting the resolution presents it as an individual member of the Kentucky Medical Association, the resolution shall be signed by him. If the author be a group of members or component society, the resolution shall be signed by the authorized spokesman for that group. Immediately after the resolution has been introduced, it shall be referred to the proper Reference Committee before action thereon is taken.

Section 9. No resolution shall be introduced in the first meeting of the House of Delegates by any member or group of members other than the Board of Trustees unless a copy thereof was furnished to the Headquarters Office at least seven days prior to its introduction. The only exception to this shall be that a resolution which has been signed by ten or more members of the House of Delegates and of which there are sufficient printed copies to distribute to each member of the House of Delegates may be received for consideration by an affirmative vote of three-fourths of the members present and voting. No new business shall be introduced in the last meeting of the House without unanimous consent, except when presented by the Board of Trustees. All new business so presented shall require the affirmative vote of three-fourths of those delegates present and voting, for adoption.

Section 10. The House shall give diligent attention to and foster the scientific work and spirit of the Association, and shall constantly study and strive to make each Annual Meeting a stepping stone to further ones of higher interest.

Section 11. It shall consider and advise as to the material interest of the profession, and of the public in those important matters wherein the public is dependent upon the profession, and shall use its influence to secure and enforce all proper medical and public health legislation, and to diffuse information in relation thereto.

Section 12. It shall make careful inquiry into the condition of the profession of each county in the State, and shall have authority to adopt such methods as may be deemed most efficient for building up and increasing the interest in such county societies as already exist and for organizing the profession in counties where societies do not exist. It shall especially and systematically endeavor to promote friendly intercourse between physicians of the same locality and shall continue these efforts until every physician in every county of the State who will agree to abide by the constitution, bylaws and other rules and regulations of the Association and the appropriate component society, has been brought under medical society influence.

Section 13. It shall encourage postgraduate work in medical centers as well as home study and research and shall endeavor to have the results of the same utilized and intelligently discussed in the county societies.

Section 14. It shall elect representatives to the House of Delegates of the American Medical Association in accordance with the Constitution and Bylaws of that body.

Section 15. It shall, upon application, provide and issue charters to county societies organized in conformity with the Constitution and Bylaws of this Association.

Section 16. The state shall be divided into the following districts:

No. 1 — Ballard, Calloway, Carlisle, Fulton, Graves, Hickman, Livingston, McCracken, and Marshall.

No. 2 — Daviess, Hancock, Henderson, McLean, Ohio, Union, and Webster.

No. 3 — Caldwell, Christian, Crittenden, Hopkins, Lyon, Muhlenberg, Todd, and Trigg.

No. 4 — Breckinridge, Bullitt, Grayson, Green, Hardin, Hart, Larue, Marion, Meade, Nelson, Taylor, and Washington.

No. 5 — Jefferson.

No. 6 — Adair, Allen, Barren, Butler, Cumberland, Edmonson, Logan, Metcalf, Monroe, Simpson, and Warren.

No. 7 — Anderson, Carroll, Franklin, Gallatin, Grant, Henry, Oldham, Owen, Shelby, Spencer, and Trimble.

No. 8 — Boone, Campbell, and Kenton.

No. 9 — Bath, Bourbon, Bracken, Fleming, Harrison, Mason, Nicholas, Pendleton, Scott, and Robertson.

No. 10 — Fayette, Jessamine, and Woodford.

No. 11 — Clark, Estill, Jackson, Lee, Madison, Menifee, Montgomery, Owsley, Powell, and Wolfe.

No. 12 — Boyle, Casey, Clinton, Garrard, Lincoln, McCreary, Mercer, Pulaski, Rockcastle, Russell, and Wayne.

No. 13 — Boyd, Carter, Elliott, Greenup, Lawrence, Lewis, Morgan, and Rowan.

No. 14 — Breathitt, Floyd, Johnson, Knott, Letcher, Magoffin, Martin, Perry, and Pike.

No. 15 — Bell, Clay, Harlan, Knox, Laurel, Leslie, and Whitley.

District meetings may be held as desired, and District Medical Associations may be organized as desired, according to the districts outlined above.

Section 17. It shall have authority to appoint committees for special purposes from among members of the Association who are not members of the House of Delegates and such committees may report to the House of Delegates in person, and may participate in the debate thereon.

Section 18. It shall approve all memorials and resolutions issued in the name of the Association before the same shall become effective, except as provided in Chapter VI, Section 4, and except for the selection of the recipient of the Kentucky Medical Association Award (Outstanding Layman) and Distinguished Service Award (Outstanding Physician), which selections shall be made by the KMA Awards Committee.

Section 19. A digest of proceedings of the House of Delegates shall be published and distributed to the membership annually.

CHAPTER IV. ELECTION OF OFFICERS AND DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Section 1. The President-Elect and the Vice President shall be elected from the state at large for a term of one year, the President-Elect succeeding to the presidency at the expiration of his term as President-Elect. A majority vote of those attending and voting shall be required for the election of the President-Elect and the Vice President and on any ballot where a majority is not obtained, the candidate with the least votes shall be dropped and further balloting held until such time as one candidate receives a majority of the votes cast. Delegates to the AMA and their alternates shall be elected from the state at large for terms of two years with the provision that no more than one delegate and no more than one alternate delegate shall be elected from one component society. The Speaker of the House of Delegates, the Vice-Speaker and the Secretary-Treasurer shall be elected for terms of three years. Trustees and their Alternates shall be elected for terms of three years and Trustees shall be limited to serving for not more than two consecutive full terms. The terms of the Trustees and their Alternates shall coincide and be so arranged that one-third of the terms expire each year, insofar as possible, provided, however, that nothing contained herein shall preclude an Alternate Trustee from serving two full terms as a Trustee. No member shall be eligible for the office of President, President-Elect, Vice-President, Secretary-Treasurer, Speaker or Vice-Speaker of the House of Delegates, Trustee or Alternate Trustee who has not been an active member of the Association for at least three years.

Section 2. During the last meeting of the regular session of the House of Delegates, the Speaker of the House of Delegates shall submit to the members of the House of Delegates a list of ten names from which, by ballot, the House of Delegates shall select five members to serve as the Nominating Committee for the next year. The five names receiving the most votes shall form the Committee, and the person receiving the most votes shall be Chairman. In the event that the Chairman so elected is unable or unwilling to serve, or in the event of a tie, the Committee shall elect one of its members as Chairman. The Commitee shall meet at such time and place as determined by the Committee Chairman or the Board of Trustees, and shall schedule an open meeting immediately after the close of the first meeting of the House at each Annual Meeting. This open meeting shall be held in the meeting place of the House of Delegates, shall receive broad publicity, and those who have business to discuss with the committee shall have a hearing. The Nominating Committee shall verify the eligiblity and willingness to serve of each candidate nominated. The Committee shall accept and post for information all eligible and willing candidates proposed for offices elected from the state at large. Before noon of the day following the opening meeting, the committee shall post on a bulletin board near the entrance to the hall in which the Annual Meeting is being held, its nomination, or nominations, for each office to be filled, and shall formally present said nomination, or nominations, to the House at the time of the election. Additional nominations may be made from the floor by submitting the nominations without discussion or comment. Vacancies occurring on the Nominating Committee by virtue of death, resignation, or disability, shall be filled by appointment of the Speaker.

Section 3. The election of officers and delegates to the AMA and their alternates shall be held at the second meeting of the regular session of the House of Delegates.

Section 4. All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect, provided, however, that when there are more than two nominees, the nominee receiving the least number of votes on the first ballot shall be dropped and the balloting shall continue in like manner until an election occurs.

Section 5. Any member may make known his availability for any office within the gift of the Association. However, it would be regarded as unseemly for any member to actively campaign for his own election.

Section 6. The Delegates representing the counties in each District form the Nominating Committee for the purpose of nominating a Trustee and an Alternate Trustee for the District concerned. This committee shall hold a well publicized meeting open to all active members of the District concerned who are in attendance at the Annual Meeting for the purpose of discussing the nomination of the Trustee and his Alternate to serve the District. Additional nominations may be made from the floor when the Nominating Committee makes its report to the House of Delegates.

CHAPTER V. DUTIES OF OFFICERS OTHER THAN TRUSTEES AND ALTERNATES

Section 1. Except as provided in Chapter II, Section 2 hereof, the President shall preside at all scientific sessions of the Association and shall appoint all committees not otherwise provided for. He shall deliver an annual address at such time as may be arranged and shall perform such duties as custom and parliamentary usage may require. He shall be the real head of the profession in the State during his term of office and so far as practicable, shall visit or cause to be visited on his behalf, the various sections of the State and assist the Trustees in building up the county societies and in making their work more practical and useful. He shall be reimbursed for his reasonable and necessary travel expense incurred in the performance of his duties as President.

Section 2. The President-Elect shall assist the President in visitation of county and other meetings. He shall become president of the Association at the next Annual Meeting following his election as president-elect. In the event of his death or resignation, or if he becomes permanently disqualified or disabled, his successor shall be elected by the House of Delegates and shall be installed as President of the Association at its next regular session.

Section 3. The Vice President shall assist the President in the discharge of his duties, and shall perform such other duties as may be prescribed by the Board of Trustees. In the event of a vacancy in the office of the President, the Vice-President shall succeed to the office of the President.

Section 4. The President-Elect and the Vice-President, when acting for and in behalf of the President, may be reimbursed for their reasonable and necessary travel expenses incurred in the performance of their duties in such amounts as may be available out of the sum appropriated in the annual budget for traveling expenses.

Section 5. The Speaker of the House shall preside at all meetings of the House of Delegates. He shall appoint all committees of the House of Delegates with the approval of the House of Delegates. He shall be a nonvoting member of said committees, and shall perform such other duties as custom and parliamentary usage may require.

Section 6. The Vice Speaker shall assume the duties of the Speaker in his absence and shall assist the Speaker in the performance of his duties. In the event of the death, disability, resignation, or removal of the Speaker, the Vice Speaker shall automatically become Speaker of the House of Delegates.

Section 7. The Secretary-Treasurer shall advise the Executive Vice President in all administrative matters of this Association and shall act as the corporate secretary insofar as the execution of official documents or institution of official actions are required. He shall perform such duties as are placed upon him by the Constitution and Bylaws, and as may be prescribed by the Board of Trustees. The Secretary-Treasurer shall demand and receive all funds due the Association, including bequests and donations. He shall, if so directed by the House of Delegates, sell or lease any real estate belonging to the Association and execute the necessary papers and shall, subject to such direction, have the care and management of the fiscal affairs of the Association. All vouchers of the Association shall be signed by the Executive Vice President or his designee and shall be countersigned by the Secretary-Treasurer of the Association. When one or more of the above-named officials are not readily available, four specifically designated representatives of the Executive Committee are authorized to countersign the vouchers, provided that in any event all vouchers of the Association shall bear a signature and a countersignature. The four members of the Executive Committee authorized to countersign vouchers shall be designated by the Board during their reorganizational meeting in September and, whenever possible should be easily accessible from the KMA Headquarters Office. All those authorized to countersign vouchers shall be required to give bond in an amount to be determined by the Board of Trustees. The Secretary-Treasurer shall report the operations of his office annually to the House of Delegates, via the Board of Trustees, and shall truly and accurately account for all funds belonging to the Association and coming into his hands during the year. His accounts shall be audited annually by a certified public accountant appointed by the Board of Trustees.

CHAPTER VI. BOARD OF TRUSTEES

Section 1. The Board of Trustees shall be the executive body of the House of Delegates and between sessions of the House of Delegates shall exercise the powers conferred upon the House of Delegates by the Constitution and Bylaws. The Board of Trustees shall consist of the duly elected Trustees and the President, the President-Elect, the Vice-President, the immediate Past-President, the Speaker, and Vice-Speaker of the House of Delegates, the Secretary-Treasurer, and the Delegates and Alternate Delegates to the American Medical Association. The Executive Committee of the Board of Trustees shall consist of the President, the Vice-President, the President-Elect, the Secretary-Treasurer, the Chairman of the Board of Trustees, the Vice Chairman of the Board of Trustees, and two Trustees to be elected annually by the Board of Trustees. A majority of the full Board, and a majority of the full Executive Committee, to-wit, 5, shall constitute a quorum for the transaction of all business by either body. Between sessions of the Board, the Executive Committee shall exercise all the powers belonging to the Board except those powers specifically reserved by the Board to itself.

Section 2. The Board shall meet daily, or as required, during the Annual Meeting of the Association and at such other times as necessity may require, subject to the call of the Chairman or on petition of three Trustees. It shall meet on the last day of the Annual Meeting for reorganization and for the outlining of the work for the ensuing year. It shall, through its Chairman, make an annual report to the House of Delegates at such time as may be provided, which report shall include an audit of the accounts of the Secretary-Treasurer and other agents of this Association and which shall also specify the character and cost of all the publications of the Association during the year, and the amounts of all other property belonging to the Association, or under its control, with such suggestions as it may deem necessary. By accepting or rejecting this report, the House may approve or disapprove the action of the Board of Trustees in whole or in part, with respect to any matter reported upon therein. In the event of a vacancy in any office other than that of President, the Board may fill the same until the annual election.

Section 3. Each Trustee shall be organizer, peacemaker and censor for his district. He shall hold at least one district meeting each year for the exchange of views on problems relating to organized medicine and for post-graduate scientific study. The necessary traveling expenses incurred by a Trustee in the line of his duties herein imposed may be paid by the Secretary-Treasurer upon a proper itemized statement but this shall not be constituted to include his expenses in attending the Annual Meeting of the Association.

Section 4. The Board shall have the authority to communicate the views of the profession and of the Association in regard to health, sanitation, and other important matters, to the public and press.

Section 5. The *Journal of the Kentucky Medical Association* shall be the official organ of the Association and shall be published under the supervision of the Board. The Editor of the *Journal* shall be elected by the Board. All money received by the *Journal* or by any member of its staff on its behalf, shall be paid to the Secretary-Treasurer on the first of each month. The Board shall provide for and superintend the publication and distribution of all proceedings, transactions, and memoirs of the Association, and shall have authority to appoint such assistants to the Editor as it deems necessary.

Section 6. All commercial exhibits during the Annual Meeting shall be within the control and direction of the Board.

Section 7. In the event of the death, resignation, removal or disability of a Trustee, between sessions of the House of Delegates, the Alternate Trustee shall succeed to the office of Trustee. In the case of disability, the Alternate shall serve until the disability is removed or the Trustee's term expires, and in the absence of the Trustee, the Alternate Trustee shall vote in his place and stead.

Section 8. The Association, upon the request of any member in good standing who is a defendant in a professional liability suit, will provide such member with the consultative service of competent legal counsel selected by the Secretary-Treasurer acting under the general direction of the Executive Committee. In addition, the Association may, upon application to the Board outlining unusual circumstances justifying such action, provide such member with the services of an attorney selected by the Board to defend such suit through one court.

Section 9. The Board shall employ an Executive Vice President whose principal duty shall be to carry out and execute the policies established by the House of Delegates and the Board. His compensation shall be fixed by the Board. The Executive Vice President shall act as general administrative officer and business manager of the Association and shall perform all administrative duties necessary and proper to the general management of the Headquarters Office, except those duties which are specifically imposed by the Constitution and Bylaws upon the officers, committees, councils and other representatives of the Association. He shall refer to the various elected officials all administrative questions which are properly within their jurisdiction.

He shall attend the Annual Meeting, the meetings of the House of Delegates, the meetings of the Board, as many of the committee and council meetings as possible, and shall keep separately the records of their respective proceedings. He shall, at all times, hold himself in readiness to advise and aid, so far as is possible and practicable, all officers, committees, and councils of the Association in the performance of their duties and in the furtherance of the purposes of the Association. He shall be allowed traveling expenses to the extent approved by the Board.

He shall be the custodian of the general papers and records of the Association (including those of the Secretary-Treasurer) and shall conduct the official correspondence of the Association. He shall notify all members of meetings, officers of their election, and committees and councils of their appointment and duties.

He shall account for and promptly turn over to the Secretary-Treasurer all funds of the Association which come into his hands. It shall be his duty to receive all bills against the Association, to investigate their fairness and correctness, to prepare vouchers covering the same, and to forward them to the Secretary-Treasurer for appropriate action. He shall keep an account with the component societies of the amounts of their assessments, collect the same, and promptly turn over the proceeds to the Secretary-Treasurer. He shall, within thirty days preceding each Annual Meeting, submit his financial books and records to a certified public accountant, approved by the Board, whose report shall be submitted to the House of Delegates.

He shall keep a record of all physicians in the State by counties, noting on each his status in relation to his county society, and upon request shall transmit a copy of this list to the American Medical Association.

He shall act as Managing Editor, or otherwise supervise the publication of *The Journal of the Kentucky Medical Association* and such other publications as may be authorized by the House of Delegates, under the guidance and direction of the Board.

He shall perform such additional duties as may be required by the House of Delegates, the Board, or the President, and shall employ such assistants as the Board may direct. He shall serve at the pleasure of the Board, and in the event of his death, resignation, or removal, the Board shall have the power to fill the vacancy. From time to time, or as directed by the Board, he shall make written reports to the Board and House of Delegates concerning his activities and those of the Headquarters Office.

CHAPTER VII. DISCIPLINE — THE JUDICIAL COUNCIL

Section 1. There is hereby created a Judicial Council composed of the Secretary-Treasurer of the Association and four members to be elected by the House of Delegates for terms of four years each. One member shall be elected from each of the traditional eastern, western, and central districts, and one member from the state at large. Members of the first Judicial Council shall be elected for terms of one, two, three, and four years, respectively so that thereafter, one member will be elected each year. The Council shall annually elect a chairman.

To be eligible for membership on the Judicial Council, a nominee shall possess at least one of the following qualifications: (1) Have served one term as an officer, trustee, or a Delegate to the AMA or (2) Have served five years as a member of the House of Delegates.

It shall be the duty of the Board of Trustees to nominate at least one candidate for each vacancy on the Judicial Council, but additional nominations may be made from the floor. Vacancies which occur between Regular Sessions of the House of Delegates, shall be filled by the Board of Trustees. No member, other than the Secretary-Treasurer shall serve more than two consecutive terms.

Section 2. The Judicial Council shall be the Board of Censors of the Association. It shall be the final arbiter of all questions involving the right and standing of members, whether in relation to other members, to the component societies, or to this Association. All charges of breach of medical ethics brought before the House of Delegates shall be referred to the Judicial Council without discussion. A member who has been convicted of a felony or of any violation of the Medical Practice Act, or who violates any of the provisions of the constitution, bylaws, or any rule or regulation of this Association, or the Principles of Ethics of the American Medical Association shall be liable to censure, fine, suspension, or expulsion upon order of the Judicial Council. Provided, however, that if in addition to discipline by the Association, the Judicial Council shall be of the opinion that the offending member's license to practice medicine shall be revoked, it shall report this to the Board of Trustees as a recommendation that the Board refer the matter to the State Board of Medical Licensure for this purpose.

Suspension shall be for a specified period during which the member shall remain liable for the payment of dues but shall not be eligible to hold office, attend business meetings or otherwise participate in Associational activities at the county, district or state levels. Upon the expiration of the period of suspension, every suspended member shall be automatically restored to all of the rights and privileges of his class of membership unless the Judicial Council determines that his conduct during the period of suspension indicates that he is unworthy of such restoration, in which event his suspension may be extended or he may be expelled.

Upon the complaint of any member or aggrieved individual involved, the

Judicial Council may initiate disciplinary proceedings against any member, and may intervene in or supersede county, individual trustee, or district disciplinary proceedings, whenever in its sole judgment and opinion, a disciplinary matter is not being handled in an expeditious manner, and may render a decision therein. In all cases in which the Association, rather than a member or aggrieved individual, appears to be the real party in interest, the Judicial Council may refer the complaint to the Board of Trustees for a determination as to whether probable cause for disciplinary action exists. If the Board of Trustees resolves this question in the affirmative, it shall so charge the respondent, and a representative of the Board shall thereupon be responsible for presenting the evidence in support of such charge at any hearing held thereon.

In all proceedings of the Judicial Council, the due process requirements of reasonable notice and a full and fair hearing shall be obseved. No recommended disciplinary decision of an individual trustee or any district grievance committee shall become effective unless and until approved by the Judicial Council.

Section 3. It shall consider all appeals from the recommended decisions of individual trustees and District Grievance Committees. In this case of appeals from the decisions of individual trustees, the Judicial Council may admit such oral or written evidence as in its judgment will best and most fairly present the facts, but all appeals from the recommended decisions of District Grievance Committees shall be considered on the record made before such committee. It shall be the duty of the Secretary to notify the parties with respect to its disposition of each case.

Section 4. The Judicial Council may hear appeals from the disciplinary orders of component societies. Provided, however, that such appeals shall be considered on the record made before the component societies.

Section 5. Efforts toward conciliation and compromise shall precede the hearing of all disciplinary cases, but the decision of the Judicial Council shall be final. A party aggrieved by the decision of the Judicial Council may seek an appeal to the Judicial Council of the American Medical Association in accordance with the jurisdiction, rules and regulations of that Association.

Section 6. Component societies are encouraged to create suitable disciplinary procedures which guarantee due process, and to dispose of all disciplinary problems which come to their attention. It is recognized, however, that it may not be feasible for some societies to do so, and the District Grievance Committees hereinafter created, are designed to meet the needs of county societies which are without a functioning grievance committee.

Section 7. The trustee of each district is hereby designated the chairman of his District Grievance Committee. The Judicial Council shall designate two additional trustees from districts adjoining that of the chairman, and the three trustees thus selected shall constitute the District Grievance Committee. All grievances which cannot be resolved by individual trustees, shall be referred to the local grievance committee or the district grievance committee for the district in which the respondent physician or county society resides.

Section 8. District Grievance Committees shall investigate every grievance coming to their attention, taking care that the physician complained of shall have ample opportunity to respond to the complaint. If, after careful investigation the complaint appears to be without merit, the committee shall so report to the Judicial Council, including sufficient facts in its report to enable Judicial Council to form its own conclusions.

If the District Grievance Committee's investigation indicates that the member may be a proper subject of disciplinary action, the committee shall, upon reasonable notice, hold a hearing at which the complainant and the respondent shall be entitled to be represented by counsel, to present the testimony of witnesses in his behalf, and to cross-examine witnesses against him. All testimony shall be under oath and shall be recorded by a competent reporter at the expense of the Association, but shall not be transcribed unless and until an appeal is taken as hereinafter provided.

When all of the testimony has been heard and all evidence received, the committee shall make written findings and recommendations which it shall transmit to the Judicial Council, furnishing copies thereof to the parties.

Section 9. Any party aggrieved by the findings or recommendations of the committee, may, within 30 days, appeal to the Judicial Council. Appeals shall be taken by filing with the Secretary-Treasurer a copy of the entire record made before the District Grievance Committee (including a transcript of the testimony, procured at the appellant's expense) together with a written statement of appeal pointing out in detail wherein the committee has erred, and directing the attention of the Judicial Council to those portions of the transcript upon which he relies, provided, however, that the Judicial Council may extend the time in which the transcript must be filed, upon request made within the initial thirty-day period.

Section 10. No report or opinion of the Judicial Council shall be considered the policy of the Association until approved by the House of Delegates. Any report or opinion of the Judicial Council submitted to the House of Delegates may be accepted or rejected or referred back to the Judicial Council but not modified by the House of Delegates.

CHAPTER VIII. COMMITTEES AND COMMISSIONS

Section 1. The Board of Trustees shall have authority from time to time to appoint, fix the duties of, and abolish such standing committees and commissions as it deems necessary or desirable to assist it in carrying on the Association's activities in the fields of business and scientific meetings, medical education and hospitals, legislation, medical services, communications and public service, and governmental medical services.

Section 2. The Executive Committee shall serve as the nominating committee for all standing committee and commission appointments, but the trustees may make additional nominations. When the Executive Committee sits as such nominating committee, the President-Elect shall serve as Chairman.

Section 3. The President, with the advice and consent of the Chairman of the Board of Trustees, may appoint temporary ad hoc committees to perform specified functions. All such committees shall expire at the end of the term of the President by whom appointed.

Section 4. No committee or commission shall have power or authority to fix or determine Associational policy or to commit the Association to any course of action, such powers being expressly reserved to the House of Delegates and the Board of Trustees.

CHAPTER IX. ASSESSMENTS AND EXPENDITURES

Section 1. The annual dues for membership in this Association shall be as follows: (1) Active Member, $400, (except those physicians elected to KMA membership within six months of the completion of their residency, fellowship or fulfillment of government-obligated service shall pay $200 their first full year of membership); (2) Life Members, no dues; (3) Associate Members, $75; (4) In-training Members, $30, except that in-training members shall not be liable for dues during the first six months of their first postgraduate year in an approved residency program in Kentucky; (5) Inactive Members, $50; (6) Student Members, no dues; (7) Service Members, no dues; (8) Special Members, no dues. The dues during the first year for any active member shall be prorated on a quarterly basis as determined by the date of his application. Dues fixed by these Bylaws shall constitute assessments against the component societies. Unless otherwise instructed by the Board of Trustees (which may institute centralized billing) the Secretary of each component society shall forward its assessments, together with its properly classified roster of all officers and members, list of delegates, and list of non-affiliated physicians of the county, to the Secretary-Treasurer of this Association as of the first day of January each year.

Section 2. Unless otherwise provided by the Board of Trustees pursuant to Section 1 hereof, any component society which fails to pay its assessments, or make the report as required, on or before the first day of April in each year, shall be held as suspended and none of its members or delegates shall be permitted to participate in any of the business or proceedings of the Association or of the House of Delegates until such requirements have been met.

Section 3. All motions and resolutions appropriating money shall specify a definite amount or so much thereof as may be necessary for the purpose, and must have prior approval of the Board of Trustees before they can become effective. No motion or resolution, the adoption of which would require a substantial expenditure of funds, shall be considered by the House of Delegates unless the funds have been budgeted or are provided by the motion or resolution.

CHAPTER X. RULES OF CONDUCT

The principles set forth in the Principles of Ethics of the American Medical Association, together with the Constitution and Bylaws of the Association and all duly adopted resolutions of the House of Delegates, shall govern the conduct of members in their relation to each other and to the public.

CHAPTER XI. RULES OF ORDER

The deliberations of this Association shall be governed by parliamentary usage as contained in the latest edition of Sturgis' Standard Code of Parliamentary Procedure, unless otherwise determined by a vote of its respective bodies.

CHAPTER XII. COUNTY SOCIETIES

Section 1. Except as provided in Section 3 of this Chapter, all county medical societies in this State which have adopted principles of organization not in conflict with this Constitution and Bylaws shall, upon application to the House of Delegates, receive a charter from and become a component part of this Association.

The House of Delegates shall have authority to evoke the charter of any component society whose actions are in conflict with the letter or spirit of the Constitution and Bylaws.

Section 2. As rapidly as can be done after the adoption of this Constitution and Bylaws, a medical society shall be organized in every county in the state in which no component society exists, and charters shall be issued thereto.

Section 3. Only one component society shall be chartered in any county. Membership in the component society thus created shall entitle the members thereof to all the rights and benefits of membership in the Kentucky Medical Association.

Section 4. In sparsely settled sections two or more component societies may join for scientific programs, the election of officers, and such other matters as they may deem advisable. The component societies thus combined shall not lose any of their privileges or representation. The active members of each component society shall annually elect at least a Secretary and a Delegate for the transaction of its business with the Association.

Two or more adjacent component societies may also combine into one multi-county component society by adopting resolutions to that effect at special meetings called for that purpose on at least ten days' notice. Copies of the resolution, certified as to their adoption by the Secretary of each society, shall be forwarded to the Headquarters Office. If approved by the Board of Trustees, the multi-county society shall thereupon be issued a charter, the consolidating county societies shall cease to exist and the multi-county society shall become a component society of this Association; provided, however, that the active members residing in each county comprising the multi-county society shall be entitled to elect a delegate or delegates to the House of Delegates, as if each such county constituted a component society within the meaning of Section 11 of this Chapter; and provided, further, that multi-county societies may elect, at large, one alternate delegate for each delegate to which it is entitled under this section and such alternate may serve in the absence of the delegate for whom he is the designated alternate.

A multi-county component society may be disaggregated so that an individual county society may regain independent status when a majority of the members in that county indicate their desire to reorganize. At that time the members from the withdrawing county shall forward a petition containing the signatures of a majority of the members in that county to be validated by KMA. The withdrawing county shall further forward a resolution to the KMA Headquarters Office to be submitted to the House of Delegates at its next regular meeting, requesting recognition as a county society and issuance of a charter, in accord with Chapter XII, Section 1 of the KMA Bylaws. Once this charter is issued, the new county society shall become a recognized entity at the beginning of the following KMA dues year and those counties remaining with the original multi-county unit may continue to function under their pre-existing charter.

Section 5. Each component society shall be the sole judge of the qualifications of its own members. All members of component societies shall be members of the Kentucky Medical Association and shall be classified in accordance with Chapter I, Section 2 of these Bylaws, provided, however, that no physician who is under suspension or who has been expelled shall thereafter, without reinstatement by the Board of Trustees be eligible for membership in any component society. Any physician who desires to become a member of the Kentucky Medical Association shall first apply to the component society in the county in which he resides, for membership therein. Except as hereinafter provided in Sections 6 and/or 8 of this chapter, no physician shall be an active member of a component society in any county other than the county in which he resides.

Section 6. Any physician who may feel aggrieved by the action of the component society of the county in which he resides, in refusing him membership, shall have the right to appeal to the Board of Trustees, which, upon a majority vote, may permit him to apply for membership in a component society in a county which is adjacent to the county in which he resides.

Section 7. When a member in good standing in a component society moves to another county in the State, his name, upon request, shall be transferred without cost to the roster of the component society into whose jurisdiction he moves, if he is admitted to membership therein.

Section 8. A physician whose residence is closer to the headquarters of an adjacent component society than it is to the headquarters of the component society of the county in which he resides, may, with the consent of the component society within whose jurisdiction he resides, hold membership in said adjacent component society.

Section 9. Each component society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material conditions of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it embraces every qualified physician in the county.

Upon reasonable notice and after a hearing, component societies may discipline their members by censure, fine, suspension or expulsion, for any breach of the Principles of Medical Ethics or any bylaw, rule or regulation lawfully adopted by such societies or this Association. At every hearing, the accused shall be entitled to be represented by counsel and to cross-examine witnesses, and the society shall cause a stenographic record to be made of the entire proceedings. The stenographer's notes need not be transcribed unless and until requested by the respondent member.

Any physician aggrieved by the disciplinary action of a component society may, within ninety (90) days, appeal to the Judicial Council, whose decision shall be final. This appeal shall be in writing and shall point out in detail the errors committed by the county society. It shall be accompanied by a transcript of the proceedings before the county society, procured at appellant's expense, and the statement of appeal shall direct the attention of the Judicial Council to those portions of the transcript upon which he relies.

Any member who fails or refuses to comply with the lawful disciplinary orders of his component society shall, if such failure or refusal continues for more than thirty (30) days, be automatically suspended from membership, provided, however, that an appeal shall stay the suspension until a final decision is made by the Judicial Council.

The resignation of a member against whom disciplinary charges are pending or who is in default of the disciplinary judgment of his county society, a district grievance committee or the Board of Trustees shall not be accepted and no member who is suspended or expelled may be reinstated or readmitted unless and until he complies with all lawful orders of his component society and the Board of Trustees.

Section 10. Frequent meetings shall be encouraged and the most attractive programs arranged that are possible. Members shall be especially encouraged to do postgraduate and original research work, and to give the society the first benefit of such labors. Official positions and other references shall be unstintingly given to such members.

Section 11. At the time of the annual election of officers, each component society shall elect a delegate or delegates to represent it in the House of Delegates. The term of a delegate shall commence on the first day of the regular session of the House following his election, and shall end on the day before the first day of the next regular session, provided, however, that component societies may elect delegates for more than one term at any election. Each component society may elect one delegate for each 25 voting members in good standing, plus one delegate for one or more voting members in excess of multiples of 25, provided, however that each component society shall be entitled to at least one delegate regardless of the number of voting members it may have and that each multi-county society shall be entitled to the same number of delegates as its component societies would have had. The secretary of the society shall send a list of such delegates to the Secretary-Treasurer of this Association not later than 45 days before the next Annual Meeting. It shall be the obligation of a component society which elects delegates to serve more than one year, to provide the KMA Headquarters Office with a certified list of its delegates each year.

Section 12. The secretary of each component society shall keep a roster of its members and a list of nonaffiliated licensed physicians of the county, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary. He shall furnish an official report containing such information upon blanks supplied him for the purpose, to the Secretary-Treasurer of the Association, on the first day of January of each year or as soon thereafter as possible, and at the same time the dues accruing from the annual assessment are sent in. In keeping such roster the secretary shall note any change in the personnel of the profession by death or by removal to or from the county, and in making his annual report he shall be certain to account for every physician who has lived in the county during the year.

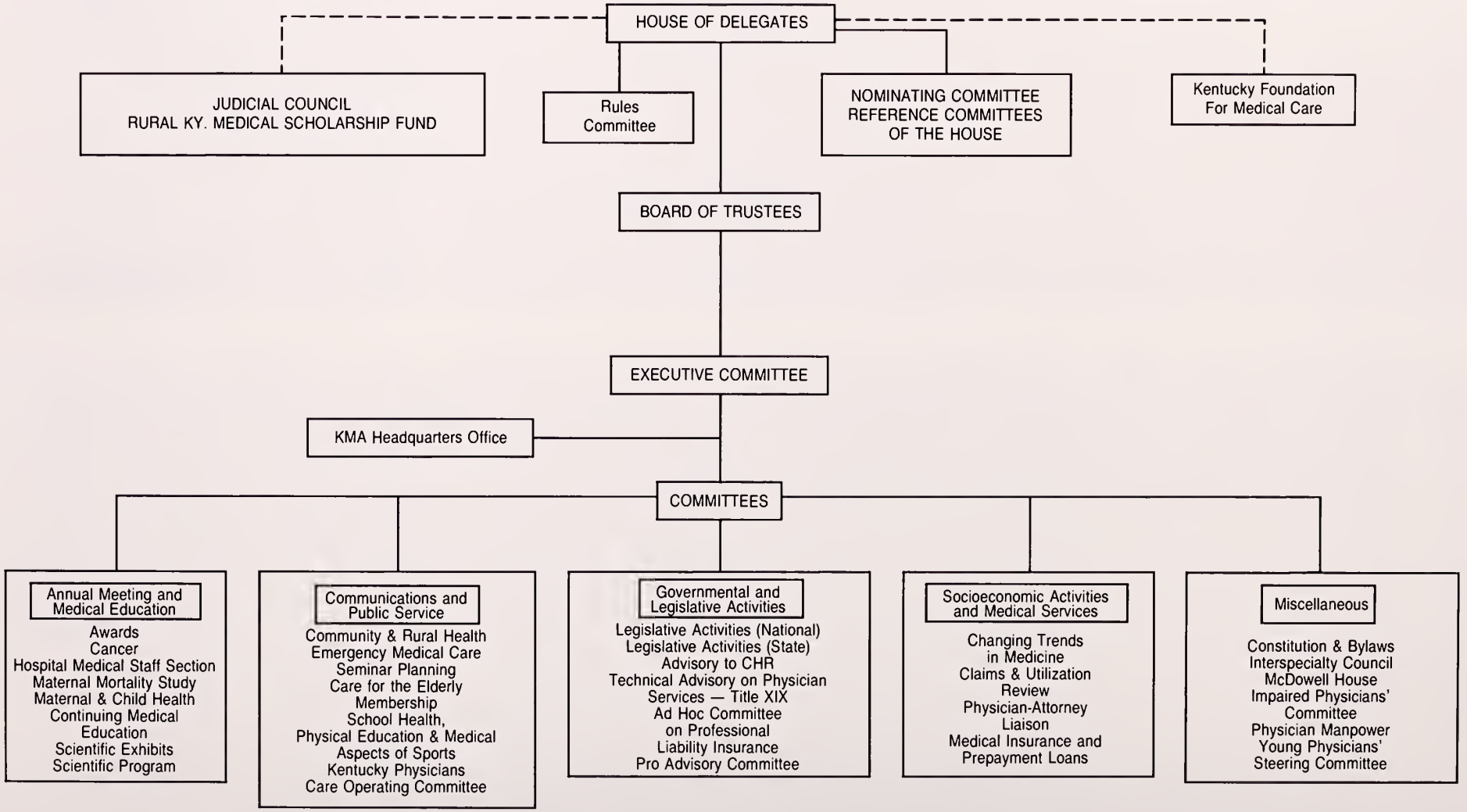
CHAPTER XIII. AMENDMENTS

Section 1. These bylaws may be amended at any session of the House of Delegates by a majority vote of the Delegates present at a meeting of that session, provided: (1) the amendment proposed is presented in writing to the Delegates thirty days prior to the meeting, or (2) the amendment is introduced in writing at a regular meeting of the House of Delegates during the session and considered at the following meeting of the session, the vote on said amendment having been postponed definitely for a period of at least one day.

Section 2. An amendment to or change in the bylaws may be proposed by a reference committee or by the Board of Trustees at the final meeting of a session of the House of Delegates but, not having been postponed definitely for a period of one day, requires a two-thirds vote.

Section 3. An amendment to these bylaws may be proposed in writing by an individual Delegate at the final meeting of a session of the House of Delegates. If such an amendment is proposed, the proposal will be postponed definitely and studied by the appropriate reference committee at that time, reporting their recommendation back to the House of Delegates before the final meeting is adjourned. Such an amendment, having not been postponed definitely for a period of one day, requires a two-thirds vote.

KMA Organization Chart—Revised September 1988



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Kentucky Dermatological Society
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Index
Annual Meeting Reports of Committees and Officers

Minutes, House of Delegates First Meeting 685
Minutes, House of Delegates Second Meeting 687
Auxiliary, Report of the President 697
Board Meetings, Summary of 700
CHR, Advisory Committee to 746
Cancer 709
Care for the Elderly 721
Chairman, Board of Trustees 698
Changing Trends in Medicine, Committee to Investigate 737
Claims and Utilization Review 736
Community and Rural Health 744
Constitution and Bylaws 758
Continuing Medical Education 708
Council for Continuing Medical Education 708
Delegates to AMA 691
Editor 690
Electiion of Officers 761
Emergency Medical Care Seminar Planning 712
Executive Vice President 692
Hospital Medical Staff Section 709
Impaired Physicians 717
Interspecialty Council 709
Judicial Council 755
KEMPAC Board of Directors, Chairman 733
KMA Physicians Services, Inc. 706
Kentucky Medical Insurance Company 695
Kentucky Physicians Care Operating 704
Maternal and Child Health 746
Maternal Mortality Study 715
McDowell House Board of Managers 758
Medical Insurance and Prepayment Plans 734
Medical Student Section 758
Membership 756
National Legislative Activities 716
Peerview Oversight 736
Physician Manpower 712
Physician Services (Title XIX), Technical Advisory 743
Physician-Attorney Liaison 760
President 696
President-Elect 689
Professional Liability Insurance, Ad Hoc Committee on 721
Professional Liability Insurors, Ad Hoc Committee on 703
Resident Physicians Section 759
Rural Kentucky Medical Scholarship Fund 756
School Health, Physical Education, and Medical Aspects of Sports 745
Scientific Exhibits 707
Scientific Program 707
Secretary-Treasurer 690
Speakers, House of Delegates 689
State Legislative Activities 718
Voluntary Medicare Assignment Program, Special Report A Board of Trustees 748
Young Physicians Steering 759

CLASSIFIEDS

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December 13-15
Advanced Trauma Life Support, University of Kentucky College of Medicine, Lexington, KY. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

December 16-17
Vascular Surgery Update, Hyatt Regency Hotel, Lexington, KY. Sponsored by the University of Kentucky College of Medicine. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

February 19-24, 1989
Twentieth Family Medicine Review — Session I, Hyatt Regency Hotel, Lexington, KY. Sponsored by the University of Kentucky College of Medicine. Contact: Joy Greene, Continuing Medical Education, 132 College of Medicine Office Building, U of K, Lexington, KY 40536-0086, (606) 233-5161.

February-May 1989
Johns Hopkins University School of Medicine 30th Annual Postgraduate Institute for Pathologists in Clinical Cytopathology. February through April 1989 — Home Study Course A; April 24 to May 5, 1989 — In-Residence Course B, a lecture series. Contact: John K. Frost, MD, or Ms. B. Clendaniel, 604 Pathology Bldg, The Johns Hopkins Hospital, Baltimore, MD 21205, (301) 955-3522.

U OF L TO TEACH CRITICAL CARE NURSING IN RURAL HOSPITALS — The University of Louisville School of Nursing is beginning a three-year project to offer critical care training for nurses in Kentucky's rural hospitals. Classes on the care and treatment of patients with pulmonary, neurological, gastrointestinal, renal, endocrine, cardiovascular, burn and trauma problems will be taught at centralized, non-urban locations throughout the state. Contact: Barbara Dermody, Project Director, at (502) 588-5366.

April 17, 1989
16th Annual Harvard Medical School Course on Intensive Care Medicine. Theme: "Critical Care — From Metabolism to Monoclonals." Cambridge Marriott Hotel, Cambridge, MA. Contact: Bart Chernow, M.D., FACP (Course Director), Dept. of Anaesthesia, Harvard Medical School/Mass. General Hospital, 32 Fruit St., Boston MA 02114: (617) 726-2858.

April 21-22, 1989
Clinical Advances for the Practicing Ophthalmologist, Hyatt Regency-Lexington, Kentucky. A one and one-half day program which will provide the practicing ophthalmologist with an updated, practical approach to refractive corneal surgery and Excimer lasers. Contact: Jennifer Sharp, The Center for Advanced Eye Surgery, Humana Hospital-Lexington, 150 North Eagle Creek Drive, Lexington, KY 40509; (606) 268-3754.

KMA
Physician Placement Service

Physician placement is another service offered by the Kentucky Medical Association. The Association acts as a clearinghouse by providing assistance to physicians seeking practice opportunities in Kentucky and to anyone who is searching for a physician.

A booklet entitled "Practice Opportunities in Kentucky" is published in January and July. We combined our services with those offered by the Kentucky Physician Placement Service, Cabinet for Human Resources, Frankfort, Kentucky. As a result, there is a substantial increase in the number of opportunities listed. If you have just completed your medical training or are interested in a change of location, you will find this booklet helpful.

Kentucky Medical Association also publishes a "Physician Seeking" list which briefly outlines the background of the physician. This list is disseminated to communities, hospitals, clinics and physicians who are seeking the services of a physician.

If you are interested in these KMA services, please contact the:

PHYSICIAN PLACEMENT OFFICE
3532 Ephraim McDowell Drive
Louisville, Kentucky 40205
Telephone: (502) 459-9790.

THE JOURNAL OF THE KENTUCKY MEDICAL ASSOCIATION

Index to Volume 86 - 1988

January	Pages 1 to 52	July	Pages 341 to 392
February	Pages 53 to 106	August	Pages 393 to 488
March	Pages 107 to 156	September	Pages 489 to 536
April	Pages 157 to 214	October	Pages 537 to 594
May	Pages 215 to 268	November	Pages 595 to 640
June	Pages 269 to 340	December	Pages 641 to 784

Edited by A. Evan Overstreet, MD
Under the Supervision of the Board of Trustees

SCIENTIFIC ARTICLES

A

Adenocarcinoma in Exstrophy and Defunctional Ureterosigmoidostomy, 409
Asthma in Kentucky, Life Threatening, 649

B

Bladder Cancer (Grand Rounds), The Use of Lasers in the Treatment of, 511
Breast Cancer, Role of Needle Localization in the Diagnosis of Occult, 229
Breast Reconstruction (Grand Rounds), 73

C

Cancer Clinical Trials and Regional Tumor Registries, Childhood, 415
Cancer Mortality Among Kentucky Residents, 1971-1985, Site-Specific, 67
Congestive Heart Failure (Grand Rounds), Angiotensin Converting Enzyme Inhibition in the Management of, 17

D

Defibrillator, Automatic Implantable Cardioverter, 289

E

Embolism Associated with Removal of Central Venous Catheters, Venous Air, 169
Encephalitis and the AIDS-Associated Organic Brain Syndrome, Subacute, 554
Endoscopic Nd:YAG Laser Therapy for Advanced Esophageal Cancer, 405

F

G

H

Hemorrhoids — Alternative Treatments (Grand Rounds), 617
Hepatitis B Viral Disease (Grand Rounds), An Update on, 181
Hypertensive Patients' Knowledge, Using a Questionnaire to Ascertain, 362
Hyperthyroid Crisis (Grand Rounds), 371
Hypertriglyceridemia Presenting as a Reversible Cause of Vertigo, 609
Hypoglycemia Managed with Tolbutamide, Recurrent Sulfonylurea Induced Nocturnal, 129

I

J

K

L

Life-Sustaining Procedures: Survey and Analysis of Kentuckians' Opinions, Foregoing, 293

M

Magnetic Resonance Imaging, Evaluation of Knee Injuries Using, 605
Mentally Ill, Incarceration of the, 174
Myoblastoma of the Bronchus, 13
Myocardial Infarction — Role of Thrombolytic Therapy and Adjuvant Angioplasty (Grand Rounds), Acute Intervention in, 561

N

O

Organ Donation in Kentucky (Grand Rounds), 243

P

Pacemaker for Ventricular Tachycardia, Scanning, 9
Pancreatitis Following Aneurysmectomy, 285
Pericardial Effusion, Minoxidil Induced, 235
Pott's Disease in Kentucky: Diagnosis and Treatment, 499

Q

R

Radiology in Fertile or Pregnant Women, Diagnostic, 353

S

Sacroiliitis — A Case Report, Pyogenic, 121
Snakebites Reported to the Kentucky Regional Poison Center 1986: Epidemiology and Treatment Suggestions, Copperhead, 61
Speech and Language Screening of Children from Birth to 6 Years of Age, 503

T

Tumor Registries, Childhood Cancer Clinical Trials and Regional, 415

U

Ureterosigmoidostomy, Adenocarcinoma in Exstrophy and Defunctional, 409

V

Valvuloplasty, Percutaneous Balloon Aortic, 124

W

Wolff-Parkinson-White Syndrome, The Surgical Treatment of, 551

X

Y

Z

SCIENTIFIC AUTHORS

A

Allen, Frank, BA, BS, 61
Amin, Elizabeth A, MD, 229

B

Bacani-Oropilla, Teresita, MD, 174
Barker, Donald E, MD, 371
Bentley, Frederick R, MD, 243
Betolone, Salvatore J, MD, 415
Borst, George C III, MD, 129
Brown, Gregory L, MD, 73

C

Corpus, Roberto P, MD, 409
Coto, Humberto, MD, 124, 235

D

DeBandi, Harry O, MD, 409
Denny, D Marty, MD, 169, 649

E

F

Faulconer, Harold T, MD, 617
Flowers, Nancy C, MD, 9

G

Garrison, R Neal, MD, 243
Giles, Chuck, MD, 499
Gray, Laman A, Jr, MD, 551

H

Harty, James I, MD, 511
Havelda, Christopher J, MD, 9
High, Dallas M, PhD, 293
Hines, Cynthia R, MD, 409
Hovsepian, Paul G, MD, 235
Howard, John P, MD, 362
Hyde, Gordon L, MD 285

I

J

Joseph, Abraham, MD, 124, 235
Jung, Sang Seol, MD, 405

K

Klamar, Jan, MD, 605
Krishnamsetty, Ramachandra M, MD, 409
Kupersmith, Joel, MD, 235, 289, 551

L

Lynch, Jenny, MD, 13

M

Matyunas, Nancy J, PharmD, 61
McClure, Rick R, MD, 17
McCready, Robert A, MD, 285
Meckler, Roy J, MD, 609
Mendieta, Jose M, MD, 169, 499
Meyer, Jack E, MD, 229

N

O

Oldham, Benjamin T, 554
Ossorio, Miquel, MD, 13, 169, 499

P

Palakurthy, Prasad R, MD, 9
Popham, Julia A, MS, 362

Q

R

Rademaker, Mary, BSc, 289
Rao, Mohan K, MD, 409
Rayburn, Joseph L, MD, 285
Roy, Thomas M, MD 169, 499
Rodgers, George C, Jr MD, PhD, 61
Roy, Thomas M, MD, 13, 499, 649

S

Saikaly, Elie P, MD, 409
Scott, Pamela, MSN, BSN, 415
Seligson, David, MD, 605
Shedlofsky, Stephen I, MD, 181
Simpson, William G, MD, 554
Singer, Igor, MBBS, FRACP, 289
Slater, A David, MD, 289, 551
Smith, Steven M, MD, 649
Snowden, Miles S, MD, 609
Sohi, G S, MD, 124
Spurlock, Carl W, PhD, 67
Steckol, Karen F, PhD, 503
Strodel, William E, MD, 371

T

Tao, David T, MD, 121
Turns, Danielle, MD, 174

U

V

Vaughan, John, MD, 605
Victor, David W, Jr, MD, 285

W

Whelan, Joseph G, Jr, MD, 353
White, Bruce David, DO, 61
Wieman, T Jeffery, MD, 405

X

Y

Z

SPECIAL ARTICLES

Cost Containment Plans, Physician Responsibility to Patients Under, 191
Jefferson County Medical Society, The Foundation of the, 251
KMA's 1988-89 Leader, 571
Our Stubbornness Allowed Us to Deliver a Jewel, 81

SPECIAL ARTICLES AUTHORS

Charles J Cronan, IV, 191
Arthur H Keeney, MD, 251
D Sue Tharp, 571
Richard S Wolf, MD, 81

SPECIAL FEATURES

Deceased Kentucky Physicians, 656
Delegate Roll Call, 681
Digest of Proceedings, KMA House of Delegates, 1988, 685
Index of Proceedings, 776
Index to Volume 86 - 1988, 779
KMA Annual Meeting Section, 668
KMA Committees, 771
KMA Constitution and Bylaws, 763
KMA Organization Chart, 770
Poem, 657

ASSOCIATION NEWS

A

AIDS Primer, "Let's Give America the Facts" —, 311
AMA Annual Meeting, 582
Annual Meeting, Kentucky's Bluegrass Region Hosts Your 1988 KMA, 389
Annual Meeting Highlights, KMA 1988, 637
Annual Meeting Preview, 207, 263, 335
Annual Meeting Section, 1988, 431
Application for Scientific Exhibits, 208
Award Recipients, Physician's Recognition, 528
Awards Nomination Form, 150
Awards, Nominations Being Accepted for Three Annual KMA, 260

B

Board of Trustees Spring Meeting, KMA, 384
Board Meeting, Digest of Proceedings of August, 580
Board Meeting, Highlights of December KMA, 146

C

Committees, 386, 634
Complaints About Fees and Costs for Medical Records and Depositions, 587
Cooper, Carl Jr, MD, Recognized by the KMA House of Delegates, 676

D

Dream, A, 258
Drug Problems, Athletic, 635

E

Emergency Medical Care Seminar, Highlights of, 526
Emergency Medical Care Seminar Program, 261

F

G

General Sessions Summaries, 461

H

I

Interim Meeting, Kentucky Physicians Attend AMA, 148

J

Journal of Your KMA, The "New Look" for Your, 205
Judicial Council, 1987 Actions of the KMA, 99

K

KEMPAC Board Meeting, 634
KEMPAC Elects Officers for 1988, 206
KEMPAC 25th Anniversary, 1962-1987, 41
KMA-HMSS Annual Meeting Scheduled for June, 260
KMA Annual Meeting, 1988,
KMA Hospital Medical Staff Section Holds Annual Meeting, 584
KMA Night on KET, 310
KMA President-Elect, Nelson B. Rue, MD, Nominated for, 529

L

Legislative Seminar, Highlights of KMA, 202

M

Mabry Joins KMA Staff, Billy J, 633
Members, A Welcome to Our New, 630
Membership Phonathons Net Renewals and New Members, 1988, 308
Memoriam, In, 532

N

O

P

Physician Advertising, Notice on, 387
Practice Management Workshops, 636

Q

R

Rural Kentucky Medical Scholarship Fund, Inc., 530

S

Scientific Program, 449

T

Technical Exhibitors, 1988, 467

U

Updates, 102, 153, 676

V

W

Workshops, 101

X

Y

Young Promoted to Executive Staff, Donna M, 633

Z

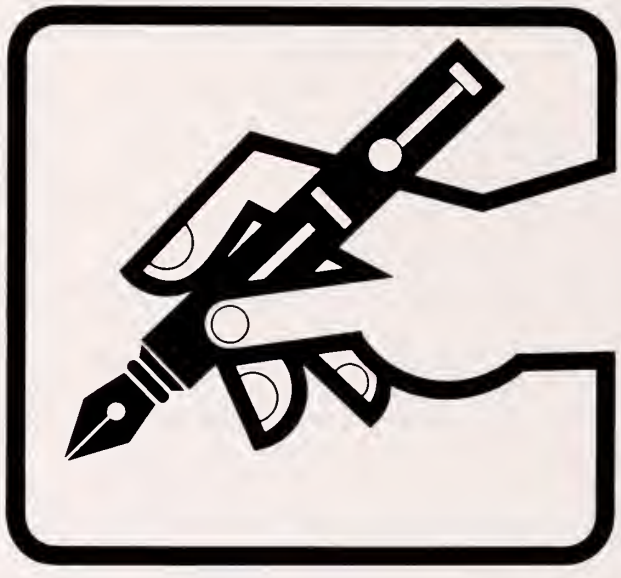
EDITORIALS

O.K. You Big Lug, Now Who's Going to Pay for All This Mess?, 23
Why Me?, 79
SZS, 133, 577
Option Chirimimba, 189
Sidewalks, 249
It's Only Over for Debbie, 301
Our Children, 379
For the Love, 421
Interference, 521
The Far Side of the Helix, 623
UCR, 661

EDITORIALS AUTHORS

Miller, Milton F, MD, 23, 421
Grider, Paul C, Jr, MD, 79, 521
Smith, Stephen Z, MD, 133, 577
Stewart, David, MD, 189, 623
Brewer, McHenry S, MD, 249, 661
Heyburn, Martha Keeney, MD, 301
Overstreet, A Evan, MD, 379

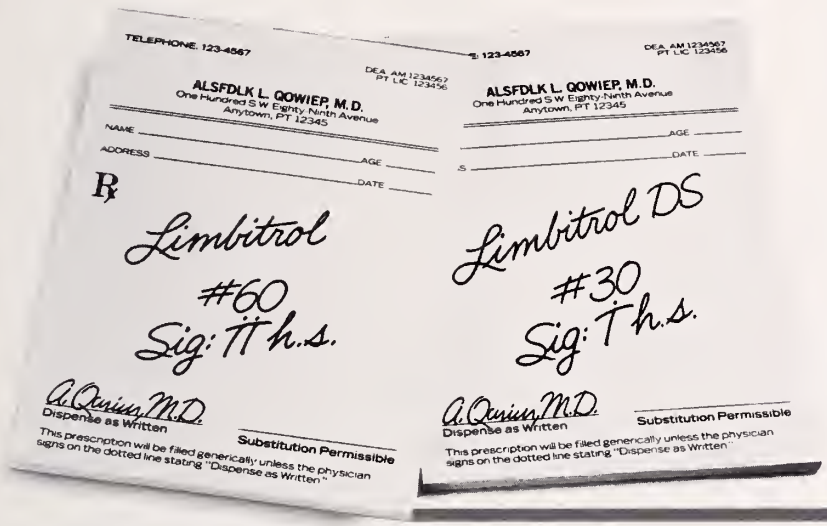
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The 139th
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will be held
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References: 1. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 2. Feighner VP, *et al: Psychopharmacology 61*:217-225, Mar 22, 1979.

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Before prescribing, please consult complete product information, a summary of which follows:

Contraindications: Known hypersensitivity to benzodiazepines or tricyclic antidepressants; concomitant use with MAOIs or within 14 days of monoamine oxidase inhibitors (then initiate cautiously, gradually increasing dosage until optimal response is achieved); during acute recovery phase following myocardial infarction.

Warnings: Use with caution in patients with history of urinary retention or angle-closure glaucoma. Severe constipation may occur when used with anticholinergics. Closely supervise cardiovascular patients. Arrhythmias, sinus tachycardia, prolongation of conduction time, myocardial infarction and stroke reported with tricyclic antidepressants, especially in high doses. Caution patients about possible combined effects with alcohol and other CNS depressants and against hazardous occupations requiring complete mental alertness (*e.g.,* operating machinery, driving).

***Usage in Pregnancy:* Use of minor tranquilizers during the first trimester should almost always be avoided because of increased risk of congenital malformations. Consider possibility of pregnancy when instituting therapy.**

Withdrawal symptoms of the barbiturate type have occurred after discontinuation of benzodiazepines (see Drug Abuse and Dependence).

Precautions: Use cautiously in patients with a history of seizures, in hyperthyroid patients, those on thyroid medication, patients with impaired renal or hepatic function. Because of suicidal ideation in depressed patients, do not permit easy access to large quantities of drug. Periodic liver function tests and blood counts recommended during prolonged treatment. Amitriptyline may block action of guanethidine or similar antihypertensives. When tricyclic antidepressants are used concomitantly with cimetidine (Tagamet), clinically significant effects have been reported involving delayed elimination and increasing steady-state concentrations of the tricyclic drugs. Use of Limbitrol with other psychotropic drugs has not been evaluated; sedative effects may be additive. Discontinue several days before surgery. Limit concomitant administration of ECT to essential treatment. See Warnings for precautions about pregnancy. Should not be taken during the nursing period or by children under 12. In elderly and debilitated, limit to smallest effective dosage to preclude ataxia, oversedation, confusion or anticholinergic effects. Inform patients to consult physician before increasing dose or abruptly discontinuing this drug.

Adverse Reactions: Most frequent: drowsiness, dry mouth, constipation, blurred vision, dizziness, bloating. Less frequent: vivid dreams, impotence, tremor, confusion, nasal congestion. Rare: granulocytopenia, jaundice, hepatic dysfunction. Others: many symptoms associated with depression including anorexia, fatigue, weakness, restlessness, lethargy.

Adverse reactions not reported with Limbitrol but reported with one or both components or closely related drugs: *Cardiovascular:* Hypotension, hypertension, tachycardia, palpitations, myocardial infarction, arrhythmias, heart block, stroke. *Psychiatric:* Euphoria, apprehension, poor concentration, delusions, hallucinations, hypomania, increased or decreased libido. *Neurologic:* Incoordination, ataxia, numbness, tingling and paresthesias of the extremities, extrapyramidal symptoms, syncope, changes in EEG patterns. *Anticholinergic:* Disturbance of accommodation, paralytic ileus, urinary retention, dilatation of urinary tract. *Allergic:* Skin rash, urticaria, photosensitization, edema of face and tongue, pruritus. *Hematologic:* Bone marrow depression including agranulocytosis, eosinophilia, purpura, thrombocytopenia. *Gastrointestinal:* Nausea, epigastric distress, vomiting, anorexia, stomatitis, peculiar taste, diarrhea, black tongue. *Endocrine:* Testicular swelling, gynecomastia in the male, breast enlargement, galactorrhea and minor menstrual irregularities in the female, elevation and lowering of blood sugar levels, and syndrome of inappropriate ADH (antidiuretic hormone) secretion. *Other:* Headache, weight gain or loss, increased perspiration, urinary frequency, mydriasis, jaundice, alopecia, parotid swelling.

Drug Abuse and Dependence: Withdrawal symptoms similar to those noted with barbiturates and alcohol have occurred following abrupt discontinuance of chlordiazepoxide; more severe seen after excessive doses over extended periods; milder after taking continuously at therapeutic levels for several months. Withdrawal symptoms also reported with abrupt amitriptyline discontinuation. Therefore, after extended therapy, avoid abrupt discontinuation and taper dosage. Carefully supervise addiction-prone individuals because of predisposition to habituation and dependence.

Overdosage: Immediately hospitalize patient. Treat symptomatically and supportively. I.V. administration of 1 to 3 mg physostigmine salicylate may reverse symptoms of amitriptyline poisoning. See complete product information for manifestation and treatment.

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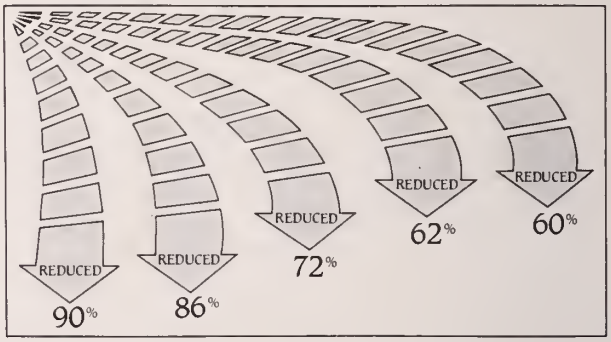
See Improvement In The First Week[1]...

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- First-week reduction in somatic symptoms[1]

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Percentage of Reduction in Individual Somatic Symptoms During First Week of Limbitrol Therapy*



*Patients often presented with more than one somatic symptom.

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